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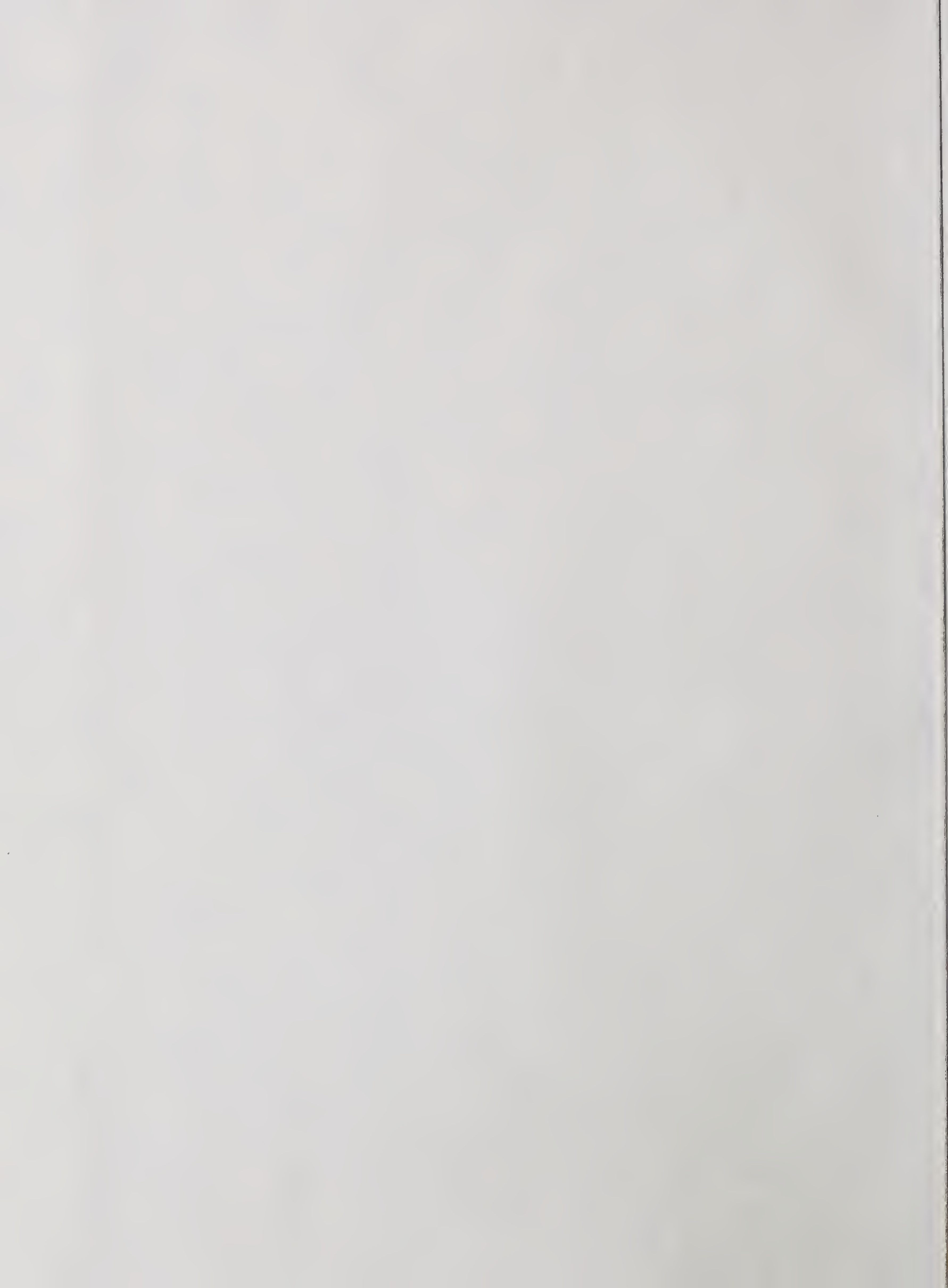

A REPORT ON THE
APRIL, 1983 FIRE AT
CENTRAL COMMUNITY HOME
IN WORCESTER, MASSACHUSETTS

EXECUTIVE OFFICE OF HUMAN SERVICES

JOHN MUDD, ACTING SECRETARY

1 ASHBURTON PLACE

BOSTON, MASSACHUSETTS 02108

I. ACKNOWLEDGEMENTS

The EOHS team would like to acknowledge the cooperation of James J. Callahan, Commissioner of Mental Health.

We would also like to thank the many interview subjects who cooperated with this investigation and provided valuable information. The team would like especially to acknowledge the cooperation of John Ford, DMH Worcester Area Director and David Higgins, Executive Director of the Worcester Area Community Mental Health Center.

The EOHS team would also like to acknowledge the assistance and cooperation of Dick Best, Senior Fire Analysis Specialist for the National Fire Protection Association, and John Merrifield and Dr. Louis Mutschler, of Emerson Hospital.

In addition, we would like to express our appreciation to Elyse Ferragamo and Robin Westhaver of the Office of State Health Planning, and Phyllis Trippe and Carol Wallace of EOHS, for their assistance.

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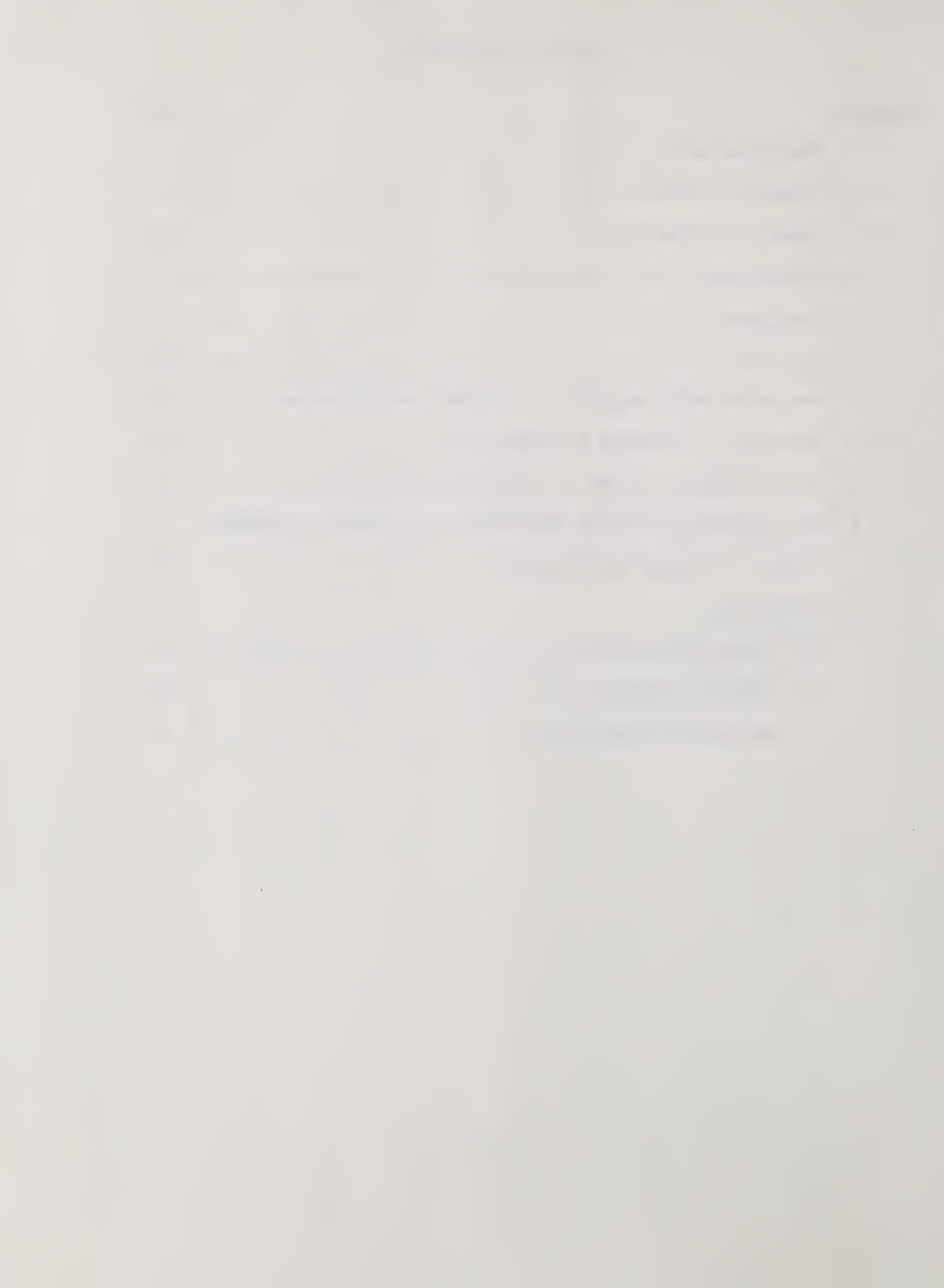


II. EXECUTIVE SUMMARY

A. GENERAL INTRODUCTION

On April 19, 1983, at approximately 2 a.m., a three-alarm fire broke out at Central Community Home, a privately owned and operated rooming house at 809 Main Street in Worcester, Massachusetts. The fire resulted in the loss of seven lives and was caused by the careless use of smoking materials.

Central Community Home primarily houses former patients from Worcester State Hospital, a Department of Mental Health facility. Of the 23 people registered at CCH on April 19, 1983, 21 were former patients at Worcester State Hospital. Every resident of the house was a current or former client of the Worcester Area Community Mental Health Center or one of its affiliate agencies.

On April 21, two days after the fire, Human Services Secretary Manuel Carballo ordered his office to conduct an independent investigation of the fire.

B. METHODOLOGY

Before developing a detailed investigation plan, the EOHS investigation team conducted a preliminary review to determine the scope and procedures of the investigation. As a result of this review, the EOHS team concluded that the investigation should have a broad scope and include an examination of:

1. The discharge decisions at Worcester State Hospital for those former patients who were residents of Central Community Home at the time of the fire;

2. The aftercare provided in the community for the residents of Central Community Home;

3. The practices of Central Community Home;

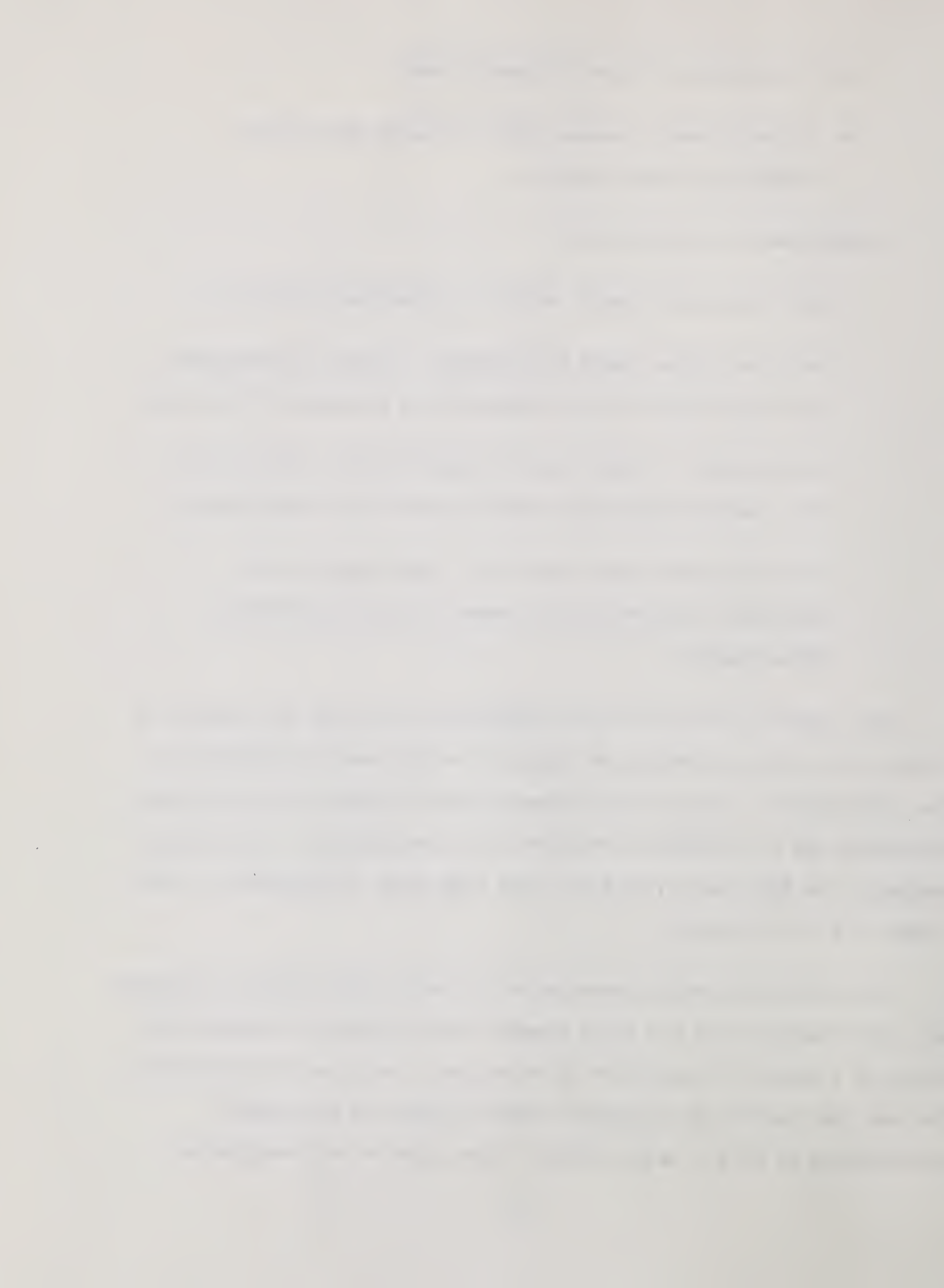
4. The relationship between Central Community Home and the Department of Mental Health.

The EOHS team also concluded that:

- The investigation should include an independent psychiatrist.
- The investigation should be preceded by a written investigative plan and should follow the principles and procedures of that plan.
- The Department of Mental Health should be given an opportunity to review and comment upon a draft report of the investigation.
- The investigation should result in a final report to the Secretary, incorporating any comments from the Department of Mental Health.

After retaining the services of a psychiatrist, the EOHS team prepared an Investigation Plan (See Appendix A) that outlined the scope and procedures of the investigation. The team then reviewed relevant documents and interviewed individuals who had information pertinent to the investigation. By the end of September, the EOHS team reviewed more than 3,000 pages of documents and interviewed more than 100 people.

The report begins with an overview of the mental health system in Worcester and a description of the fire which prompted the investigation including findings from a separate investigation by the National Fire Protection Association. The next four sections of the report include findings and discussions corresponding to the four areas outlined in the scope of the investigation:



1. The policies and practices of Worcester State Hospital;

2. Aftercare in the Worcester area mental health system;

3. The operation of Central Community Home;

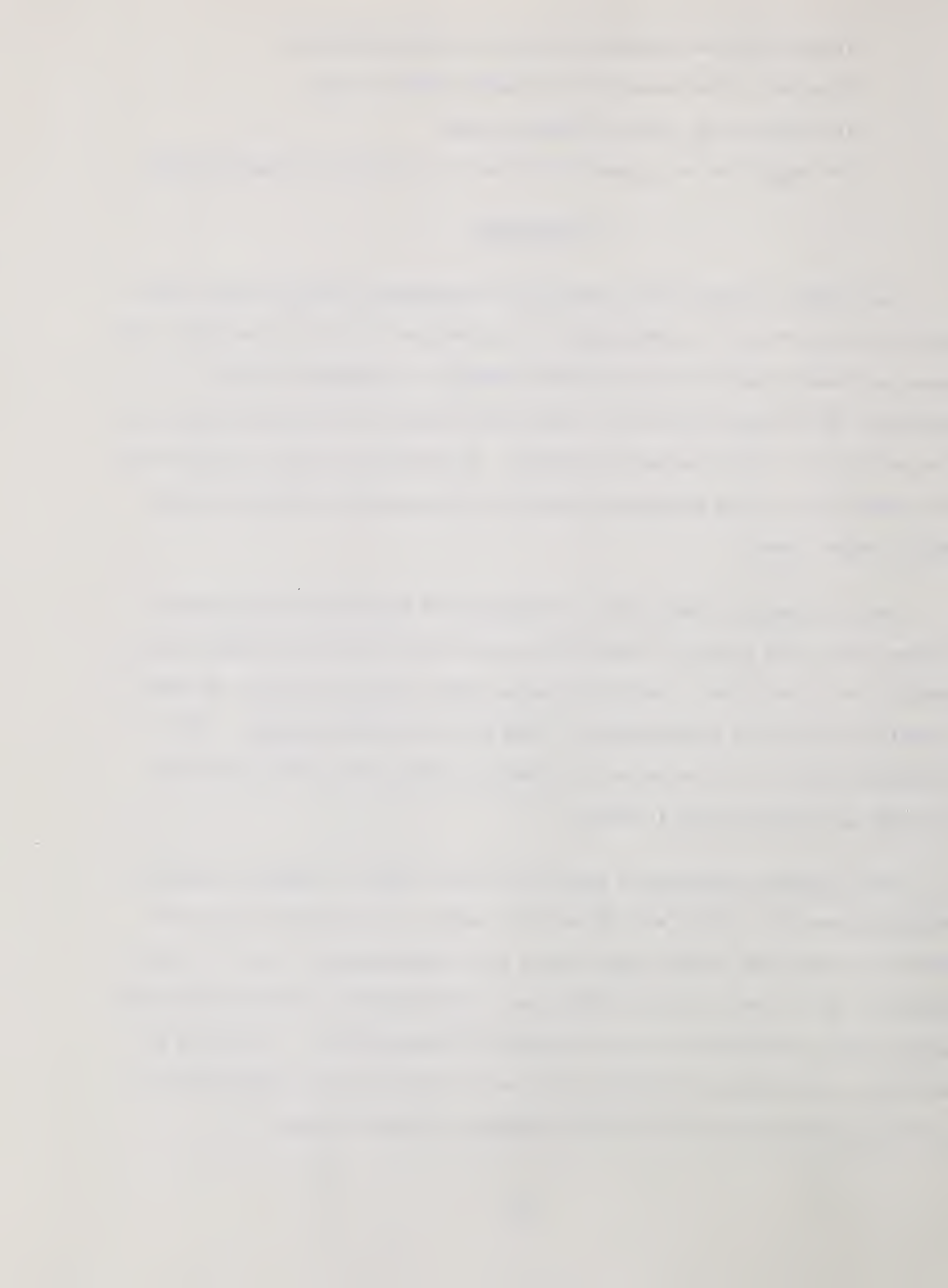
4. The regulation of private facilities such as Central Community Home.

C. BACKGROUND

The greater Worcester Area served by the Department of Mental Health (DMH) Worcester Area office is in DMH Region II and includes the city of Worcester and seven surrounding towns. The Area Office operates an inpatient unit at Worcester State Hospital (WSH) and finances more than 40 contracted programs for the mentally ill and the mentally retarded. The largest provider of services to the mentally ill in the Worcester community is the Worcester Community Mental Health Center (CMHC).

Central Community Home (CCH) is located at 809 Main Street in Worcester. At the time of the fire, the three-story wood frame building was equipped with a manual fire alarm system, a multiple-station smoke detection system, emergency lighting and portable extinguishers. There was no sprinkler system. CCH is licensed by the city of Worcester as a lodging house, and at the time of the fire met all applicable local codes.

The 23 people registered at CCH on the day of the fire ranged in age from 25 to 60 years old. There were 15 men and 8 women. All but one of the residents were receiving federal and/or state assistance benefits. Of the 21 residents who were former patients at Worcester State Hospital, all were considered by the EOHS team psychiatrist to be "chronically mentally ill." According to Worcester State Hospital records, all 21 had a history of prior admissions to state psychiatric facilities for the treatment of mental illness.



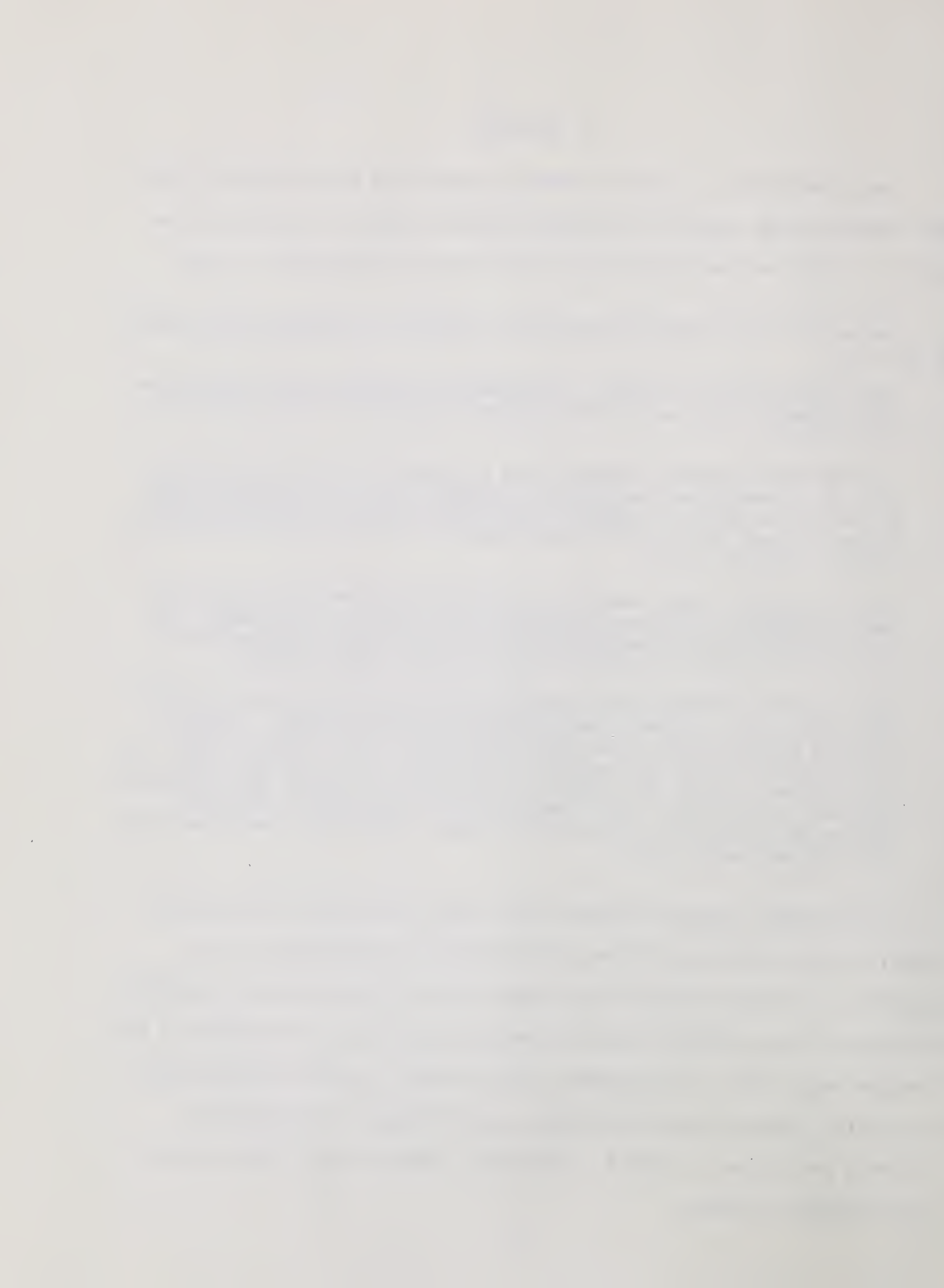
D. THE FIRE

Twenty people were in Central Community Home at the time of the fire. Of the remaining three registered residents, two had returned to Worcester State Hospital in the week preceding the fire, and one was staying with a friend.

The National Fire Protection Association offered the following description of the fire:

> Twenty occupants were located in sleeping rooms on the first, second, and third floors. There was no staff person at the Community Home when the fire occurred.
>
> A second-floor occupant discovered the fire under his bed at about 2:00 a.m. He attempted unsuccessfully to extinguish the fire and then dragged or carried the mattress along the second-floor corridor to the bathroom where it flared into a full-flaming condition. The occupant ran downstairs and out of the building.
>
> The fire alarm or smoke detection system activated and most of the occupants were able to evacuate, unassisted, using the front stairway. The fire rapidly spread throughout the second floor creating untenable conditions on the second and third floors including both stairways.
>
> The Worcester Fire Department received an alarm at 2:21 a.m. and reported very heavy smoke throughout the building upon their arrival. The fire fighters conducted search and rescue operations. Fire fighters using self-contained breathing apparatus located four victims in two rooms. One of those four victims was located in a closet. Two victims were located in one room on the second floor. The seventh victim died as a result of falling or jumping from a third-floor window. One other occupant and five fire fighters were injured.

Investigators from the Offices of the State Fire Marshal, the Worcester County District Attorney's Office, the Worcester Fire Department and the National Fire Protection Association agreed that the fire at CCH was accidental, and caused by the careless disposal of smoking materials by the occupant in Room 9 on the second floor. Investigators confirmed their findings through laboratory tests, studies of evacuation paths, and interviews of the residents, including the occupant of Room 9. Interviews conducted by the EOHS team also confirmed these findings.



The investigation conducted by the NFPA draws the following conclusions about the fire:

> The smoke detection and alarm system in the Central Community Home did not provide adequate protection for the occupants, given the combustible interior finish, inadequate means of egress, lack of compartmentation, lack of sprinkler protection, and lack of supervision in the facility. Although the occupants were apparently alerted early to the fire, they did not have time to escape from the building before existing access corridors and the exits themselves became untenable due to the fire.
>
> Based on NFPA's investigative study, the following are considered to be the major contributing factors to the loss of life in the Central Community Home Fire:
>
> 1. Stairs were not enclosed with fire barriers or protected.
> 2. The fire was not extinguished in its incipient stage.
> 3. The presence of combustible interior finish in exits and exit access corridors.
> 4. Fire exit drills were not conducted at the Central Community Home.
> 5. There was neither a direct fire alarm connection to the fire department nor a staff person on duty when the fire occurred to provide immediate notification to the fire department.

E. WORCESTER STATE HOSPITAL

The full text of the report contains findings and detailed discussions that support these findings. For the purposes of the Executive Summary, these findings are listed alone in this and the following three sections:

1. Treatment on the GWU was affected by high census levels, low staffing levels, and the unit's institutional character; treatment consists primarily of crisis intervention, stabilization through medication, and custodial care.

2. DMH does not have clear policies or standards to guide discharge decisions by hospital clinicians. One result of the absence of such policy was that

Some patients were kept in the hospital longer than clinically appropriate while others were discharged into settings that may have been inappropriate and unsafe.

3. Discharge planning and the development of aftercare plans were inadequate, minimally recorded, and did not include assessments of a variety of skills,including self-preservation and daily living skills.

4. GWU patients living in the community on extended visit status were not treated or monitored by GWU staff, nor were special efforts made by the GWU to ensure that these patients were seen by CMHC staff.

5. There was insufficient coordination of discharge and aftercare planning between the GWU and the CMHC.

6. The discharge of patients to CCH was a regular and accepted practice on the GWU and was often made without full knowledge of the levels of supervision and safety in the home.

7. Patient records on the GWU were seriously inadequate.

8. The staff of the GWU did not follow the unit's established policies and procedures.

F. <u>AFTERCARE</u>

1. The CMHC provides a range of support services appropriately located in the community where many of their clients live.

2. Treatment and monitoring of clients by CMHC varied widely.

3. Despite generally good documentation practices, CMHC records contain some deficiencies.

4. The CMHC service primarily responsible for crisis intervention and admission decisions to the greater Worcester unit at Worcester State Hospital has been moved to a location less accessible to those who need its services.

5. There is a regular group of aftercare clients in need of emergency mental health services.

6. Because of a lack of alternatives, CMHC staff considered CCH to be an acceptable residence for their clients.

7. CMHC direct care staff voiced serious complaints about client care and safety at CCH and other boarding houses. Some of these problems were addressed after the fire.

8. There is not enough housing with a range of levels of structure and supervision for the mentally disabled in the Worcester area.

G. <u>CENTRAL COMMUNITY HOME</u>

1. From its inception, CCH has purported to offer care and supervision to mentally disabled residents and has been tacitly accepted as part of the mental health system in the Worcester area.

2. Although CCH met all applicable building and fire safety codes at the time of the fire, it was an unsafe environment for many of the residents living there.

3. The number and training of the staff at CCH was inadequate in light of the needs of its residents, the expectations of GWU and CMHC staff, and its claim to be a residence appropriate for mentally disabled people.

4. There was potential for abuse of the financial relationship between residents and the owner of CCH.

5. Despite widely reported complaints about CCH, the home is relied upon as a housing option for that segment of the mentally disabled population who require a significant level of freedom and flexibility in their living arrangements.

6. Many mentally disabled people currently live in lodging houses in Worcester that have less supervision and fewer safety provisions than CCH.

H. THE LICENSING OF PRIVATE RESIDENTIAL FACILITIES: A NATIONAL ISSUE

1. The Department of Mental Health does not have a mechanism to regulate facilities such as CCH which are not operated, licensed or funded by the department.

2. The Commissioner of Mental Health has directed DMH area offices to ensure that all programs with which they contract or to which they refer clients have current licenses from appropriate licensing authorities.

3. The Department of Public Health is prohibited by statute from licensing a facility such as central community home, although it does have the authority to license rest homes for elderly people.

4. CCH is the type of facility that has provoked a national concern about board and care homes, which led to the enactment of the Keys Amendment.

5. If Massachusetts were in full compliance with the Keys Amendment, CCH might have been regulated by a state agency and would have had to meet additional standards.

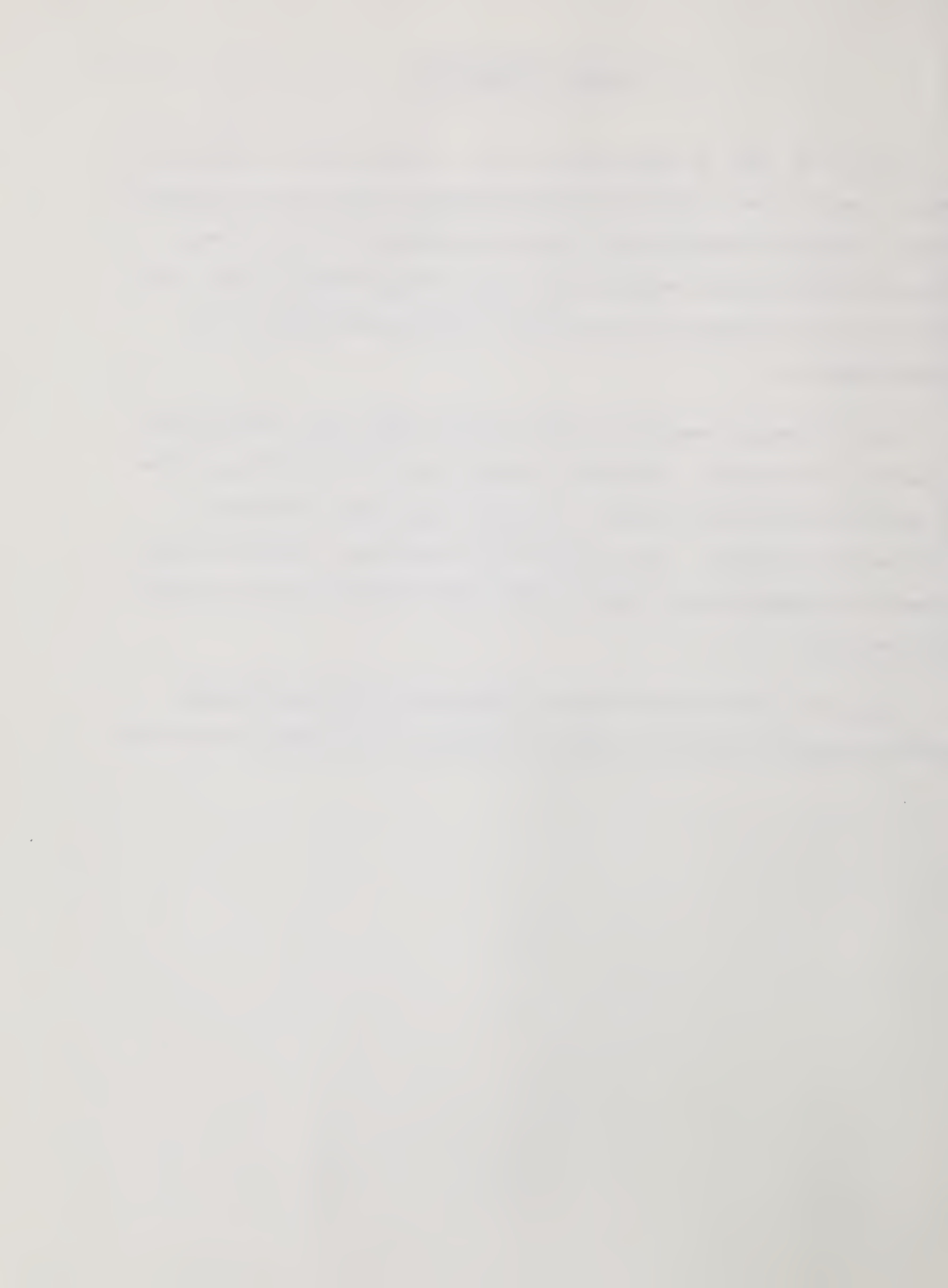
6. If CCH were licensed as a Keys Amendment facility, the Commonwealth could authorize the payment of higher benefit levels to residents eligible for social security. This additional revenue could offset the cost of additional requirements imposed through regulation.

III. GENERAL INTRODUCTION

On April 19, 1983, at approximately 2 a.m., a three-alarm fire broke out at Central Community Home, a privately owned and operated rooming house at 809 Main Street in Worcester, Massachusetts. The fire resulted in the loss of seven lives and caused extensive damage to the three-story wood frame building. Fire officials later determined the cause of the fire to be the careless use of smoking materials.

Central Community Home (CCH) primarily houses former mental patients from Worcester State Hospital, a Department of Mental Health (DMH) facility. Of the 23 people registered at CCH on April 19, 1983, 21 were former patients at Worcester State Hospital. Every resident of the house was a current or former client of the Worcester Area Community Mental Health Center or one of its affiliate agencies.

On April 21, two days after the fire, Human Services Secretary Manuel Carballo ordered his office to conduct an independent investigation of the fire.



IV. METHODOLOGY

Before developing a detailed investigation plan, the EOHS team conducted a preliminary review to determine the scope and procedures of the investigation. Meetings and discussions were held with: the state police officer from the Worcester County District Attorney's office investigating the fire; members of the Special Senate Committee on Deinstitutionalization formed on April 20 after the fire; and Department of Mental Health Central, District, and Area staff.

As a result of these discussions, EOHS concluded that the investigation should have a broad scope and include an examination of:

1. The discharge decisions at Worcester State Hospital for those former patients who were residents of Central Community Home at the time of the fire;

2. The aftercare provided in the community for the residents of Central Community Home;

3. The practices of Central Community Home;

4. The relationship between Central Community Home and the Department of Mental Health.

The EOHS team also concluded that:

- The investigation should include, as an expert consultant, an independent psychiatrist who would evaluate the discharge decisions

at Worcester State Hospital and aftercare provided in the community for each resident of Central Community Home. The psychiatrist should be familiar with institutional psychiatric care, aftercare in the community, and the structure of the Department of Mental Health, but should be independent of the Department of Mental Health.

- The investigation should be preceded by a written investigative plan and should follow the principles and procedures of that plan.

- The Department of Mental Health should be given an opportunity to review and comment upon a draft report of the investigation.

- The investigation should result in a final report to the Secretary, incorporating any comments from the Department of Mental Health.

The EOHS team then conducted an extensive search for a psychiatrist. Twenty-five psychiatrists and mental health professionals were consulted and four were interviewed. Dr. Arthur Papas, a staff psychiatrist at Emerson Hospital in Concord, Massachusetts, was chosen for the investigation. Dr. Papas is an instructor in psychiatry at Harvard Medical School and formerly taught psychiatry at Tufts Medical School. From 1973 to 1978, he served as director of psychiatry at Metropolitan State Hospital, and is familiar with the structure and practices of the Department of Mental Health.

The EOHS team then prepared an Investigation Plan (See Appendix A) that

outlined the scope and procedures of the investigation, and included:

1. Methods of securing access to and maintaining confidentiality of records.
2. A list of potential interview subjects.
3. Guidelines for interviews.
4. A description of members of the EOHS team.
5. A preliminary statement to interview subjects, including their rights under the investigation.
6. A standard list of questions.

Once the scope of the investigation was established, members of the team began to review relevant documents and to interview individuals who had information pertinent to the investigation.

By the end of September, the EOHS team reviewed more than 3,000 pages of documents and interviewed more than 100 people, many in tape-recorded sessions in Worcester. Documents reviewed included:

1. Worcester State Hospital and Worcester Area Community Mental Health Center clinical records of the residents of Central Community Home.
2. DMH Central, District and Area Regulations, Guidelines, Memoranda, Organizational Charts, and Special Reports.
3. Worcester State Hospital and Worcester Area Community Mental Health Center Policies, Procedures, Memoranda, Organizational Charts, and Special Reports.
4. National and state reports and articles on community mental health, fire safety, homelessness, deinstitutionalization, and related issues.

5. Fire investigation reports and licensing records.

6. Newspaper reports.

Interviews were conducted with:

1. Department of Mental Health Central, Region, and Area staff.

2. Administrative and clinical staff of the Greater Worcester Unit of Worcester State Hospital.

3. Administrative and clinical staff of the Worcester Area Community Mental Health Center.

4. The owner and staff of Central Community Home.

5. Residents of Central Community Home and other clients of the Worcester mental health system.

6. Other people involved in providing mental health and human services in Worcester, concerned citizens, and anyone offering information or asserting a complaint about the Central Community Home, or about the Worcester area mental health system.

7. State and national authorities in fire safety, community mental health, and licensing.

8. Representatives from the Worcester Fire Department, the Worcester County District Attorney's Office, the National Fire Protection Association, and the Worcester Code Enforcement Agency.

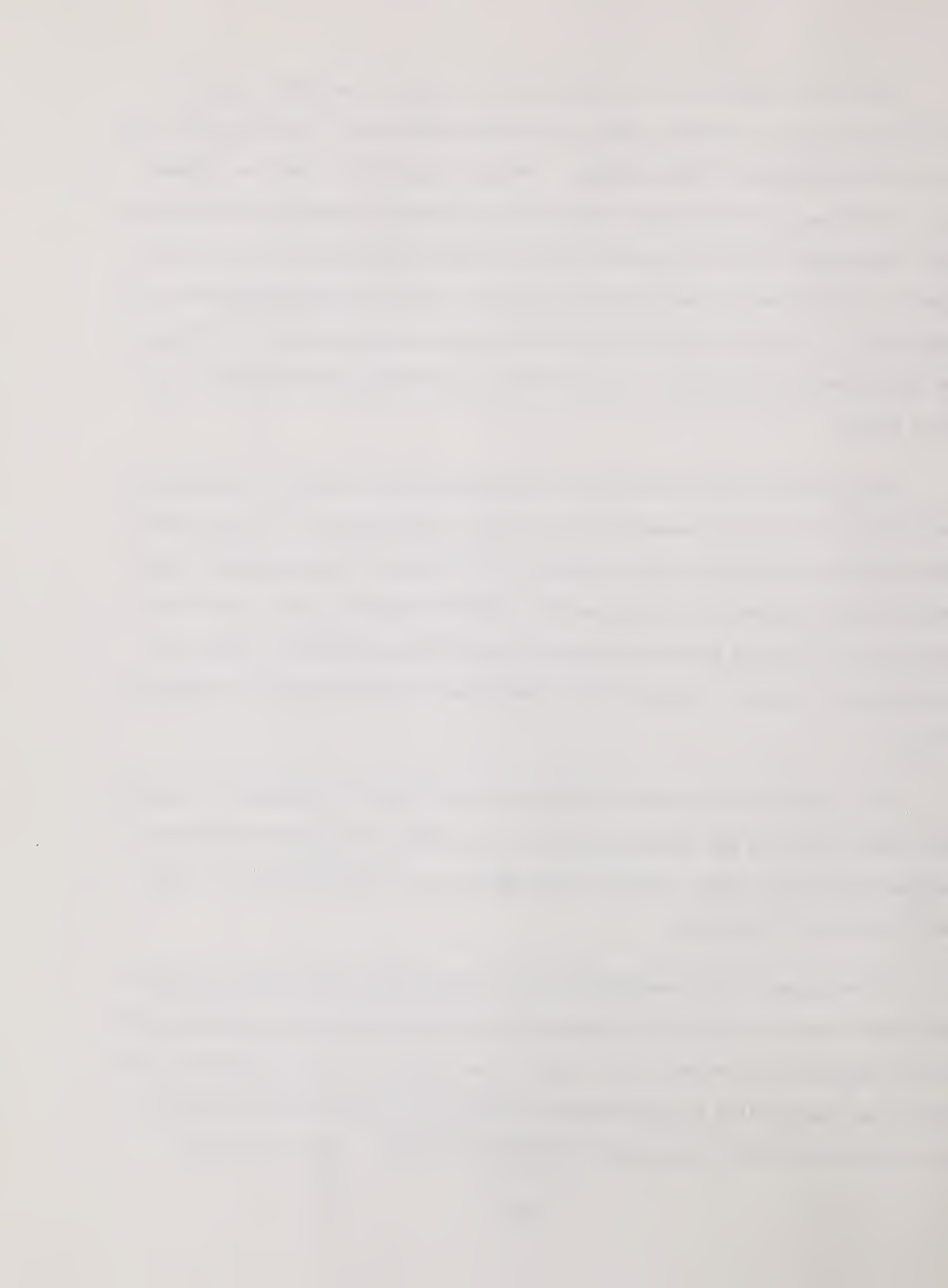
9. Representatives of the Trustees of Worcester State Hospital and the Worcester Area Mental Health Board.

After an introduction to the mental health system in Worcester and the residents of Central Community Home, the report begins with a description of the fire which prompted the investigation. The EOHS team did not make an independent determination of the cause of the fire, but rather, adopted the findings of the investigators from the National Fire Protection Association, the State Fire Marshal, the Worcester County District Attorney's Office, and the Worcester Fire Department. Information obtained by the EOHS team did corroborate the findings of these other investigators. These findings are summarized in Section VI of this report.

Each of the next four sections of the report,VII-X, includes findings and a discussion of the facts supporting the findings, relating to: (1) the policies and practices of Worcester State Hospital, (2) aftercare in the Worcester area mental health system, (3) the operation of Central Community Home, and (4) the regulation of private facilities such as Central Community Home. These areas correspond to the four subjects first identified as the focus of the investigation.

All information that could not be verified directly by reference to records or statistical data was corroborated by at least three interview subjects with a knowledge of the issue. Serious disagreements over certain facts or issues will be noted in the text.

At the start of the investigation, the DMH Worcester Area Office provided the EOHS team with a list of 23 registed CCH residents that was prepared by DMH staff immediately after the fire. Late in the course of the investigation, the EOHS team learned that a 24th person was registed at Central Community Home at the time of the fire, and was not included on the list. This resident was



readmitted to Worcester State Hospital on the evening of April 18, only hours before the fire, and was therefore not present in the house at the time of the fire.

Since the investigation focused on the 23 residents named in the original list, this 24th resident is not included in statistical data. This person, like other CCH residents, had multiple admissions to WSH and other mental health hospitals during the past 24 years. This resident has been a client of the CMHC since May of 1979, and is currently assigned to the Outpatient Department of the CMHC.

The following abbreviations are commonly used in this report:

1. Central Community Home (CCH)
2. Department of Mental Health (DMH)
3. Department of Public Health (DPH)
4. Emergency Mental Health Services (EMHS)
5. Executive Office of Human Services (EOHS)
6. Greater Worcester Unit (GWU)
7. Intensive Services Unit (ISU)
8. National Fire Protection Association (NFPA)
9. Outpatient Department (OPD)
10. Social Security Administration (SSA)
11. Worcester Area Community Mental Health Center (CMHC)
12. Worcester State Hospital (WSH)

V. BACKGROUND

A. The Mental Health System

The greater Worcester Area served by the Department of Mental Health (DMH) Worcester Area office is in DMH Region II and includes the city of Worcester and seven surrounding towns. The total population of the area is 240,000. The chief administrative officer of the area is the Area Director who reports to the District II Manager. An active Area Board participates in advising the Area Office and the Area Office maintains ties with the University of Massachusetts Medical Center. The Greater Worcester Area Office operates an inpatient unit at Worcester State Hospital and finances more than 40 contracted programs for the mentally ill and the mentally retarded. The largest provider of services to the mentally ill in the Worcester community is the Worcester Community Mental Health Center (CMHC).

B. Worcester State Hospital

Established in 1833, Worcester State Hospital was the first public mental hospital in the country. Located on large grounds overlooking Lake Quinsigamond, only one of the hospital's buildings still houses patients.

Like other state mental hospitals in Massachusetts and throughout the country, the census at Worcester State Hospital has dropped dramatically in the last 30 years. In 1950, there were 2800 patients, in 1962 there were 1725 patients, and by 1973 only 579. The current average monthly census is 400 patients, up from a 1982 low of 366.

Worcester State Hospital consists of four geographic units, a geriatric (Regional) unit, a mental retardation unit, and a medical unit. The Department of Mental Health (DMH) District II Manager is the chief executive officer of the hospital and is responsible for ensuring that the facility operates and complies

with applicable statutes, regulations and standards. Each Area Director within the District manages the clinical and programmatic operations of the geographic unit that corresponds to the area. A separate Facility Director manages all ancillary services at the hospital. In a June 1983 report to the Worcester Area Board, the Area Director wrote, "Although there are many long-term clients in the hospital, as much as possible Worcester State Hospital attempts to operate as a hospital, i.e., diagnosis, treatment and return to the community as soon as possible."

Worcester State Hospital lost its Medicaid certification in October of 1981. The deficiencies cited included inadequate nursing staff levels, record-keeping, and pharmacy practices, and problems with the physical plant. In conjunction with technical assistance provided by the Department of Public Health, hospital administrators have been revising policies and procedures to address the deficiencies. Capital requests needed to correct some of the physical deficiencies are pending. Hospital administrators project that all the cited problems, other than physical deficiencies for which funding is necessary, will be corrected by early 1984.

C. Aftercare and The Worcester Area Community Mental Health Center

Once discharged into the community, clients receive therapeutic and rehabilitative aftercare services primarily through the Worcester Area Community Mental Health Center (CMHC) or one of its affiliate agencies. A private, non-profit corporation, the CMHC provides clinical, residential and emergency services to approximately 4,000 clients per year. The CMHC was organized in 1977 after a lenghty planning process that involved DMH Area Board members and nearly 100 community representatives. Initially, the CMHC was planned as a central administrative agency that would oversee affiliated, decentralized direct service

agencies. Partly as a result of a 1980 management study, a decision was made to consolidate the provision of all core adult services in Worcester within the CMHC. This decision, approved in December of 1981, took effect on July 1, 1982. Since that time, additional services have been added to the consolidated CMHC. The CMHC is financed through contracts with the Department of Mental Health, federal funding, third-party payments and client fees. In addition, 30 DMH-paid employees work for the CMHC.

A shortage of available housing in Worcester limits choices for CMHC clients who live in settings ranging from single-family homes to shelters for the homeless. Many clients of the aftercare system live in private lodging houses in the Main South area of Worcester. Central Community Home is one such home.

D. Central Community Home and Its Residents

Central Community Home (CCH) is located at 809 Main Street in Worcester. A three-story wood frame building approximately 80 years old, CCH also includes a one-story community kitchen and dining room that adjoins the building on the south side. The building's first floor contains two offices, a T.V. room and bathroom, and three residental rooms. There are five residential rooms on both the second and third floor, a T.V. room on the second floor, and a washing machine and dryer on the third floor. At the time of the fire, the building was equipped with a manual fire alarm system, a multiple-station smoke detection

system, emergency lighting and portable extinguishers. There was no sprinkler system. CCH is licensed by the city of Worcester as a lodging house and at the time of the fire met all applicable local codes.

The 23 people registered at CCH on the day of the fire ranged in age from 25 to 60 years old. There were 15 men and eight women. Twenty-one of the people were former patients at Worcester State Hospital and one had been a patient at Medfield State Hospital. Twenty-one of the residents were current clients of the Worcester Area Community Mental Health Center, or one of its affiliates. Both of the remaining two residents had been served in the past by the CMHC or one of its affiliates. Twenty-two of the residents were receiving federal and/or state assistance benefits and the remaining individual had received such benefits in the past.

Of the 21 residents who were former patients at Worcester State Hospital, all were considered by the EOHS team psychiatrist to be "chronically mentally ill." Of the 21 former WSH patients, 15 were diagnosed as having chronic undifferentiated schizophrenia, four were diagnosed as paranoid schizophrenics, and two were diagnosed as manic depressives. In addition, four had a double diagnosis of one of the above and alcoholism, and four carried a double diagnosis of one of the above and mental retardation. At the time of their discharge from WSH, most of the residents were prescribed low to moderate doses of medication.

According to the Worcester State Hospital records, all 21 had a history of prior admissions to state psychiatric facilities for the treatment of mental illness. The lowest number of admissions was for one client who had two admissions to state facilities starting in 1975; the highest number was for

another resident who had twelve admissions dating back to 1958. The average number of admissions was 5.5. The number of official admissions, however, does not adequately represent the number or duration of hospitalizations for each resident. Many had been placed on "Extended Visit" status (explained more fully later), and repeatedly returned to the hospital from visits to the community. In these cases, the record only indicates a "return from visit," and not a formal admission. One resident, for example, had nine returns from visit from his most recent admission in 1977 until his discharge in 1983.

VI. THE FIRE

Twenty people were in Central Community Home at the time of the fire. Of the remaining three registered residents, two had returned to Worcester State Hospital in the week preceding the fire, and one was staying with a friend.

The following account of the fire is taken from the report of the National Fire Protection Association (NFPA), a non-profit organization which develops fire protection codes and standards, provides technical assistance to state and local fire officials, analyzes fires "of technical and educational value", and conducts public education programs:

> Some time around 2:00 a.m. on April 19, 1983, the occupant of Room 9, the rear corner (northeast) room on the second floor, discovered a fire under his bed. He reportedly attempted to blow it out, then to beat it out without success. He then went to the bathroom for water to use to extinguish the fire. Still unable to control the fire, he dragged or carried the polyurethane foam mattress to the bathroom to try to put the fire out.
>
> Once inside the bathroom, the mattress suddenly flared into a full-flaming condition. The room occupant abandoned his efforts to extinguish the fire and ran downstairs and out of the building.
>
> The fire alarm or smoke detection system activated and most of the occupants were able to evacuate, unassisted, using the front stairway. The occupant in Room 12 on the third floor tried to use the rear stairway, but found there was too much smoke. He went to the front stairway and found it was also filled with smoke. He was able to exit from the building using the front stairs, but could not see because of the smoke. The fire rapidly spread throughout the second floor creating untenable conditions on the second and third floors, including both stairways.
>
> One occupant ran to notify the security person who was in another building about one block away. The security person telephoned the fire department. Simultaneously, two passersby saw the fire and telephoned the fire department.
>
> The Worcester Fire Department received an alarm at 2:21 a.m. First arriving companies reported very heavy smoke throughout the building on their arrival. Fire fighters were told that there were people in the building and a person at the rear ready to jump. Ground ladders were raised; a 2 1/2 inch line was advanced in the front entrance and entry was attempted at the rear. Aerial towers and an aerial ladder were utilized at the front of the

building, but other areas of the building were not accessible to aerial apparatus.

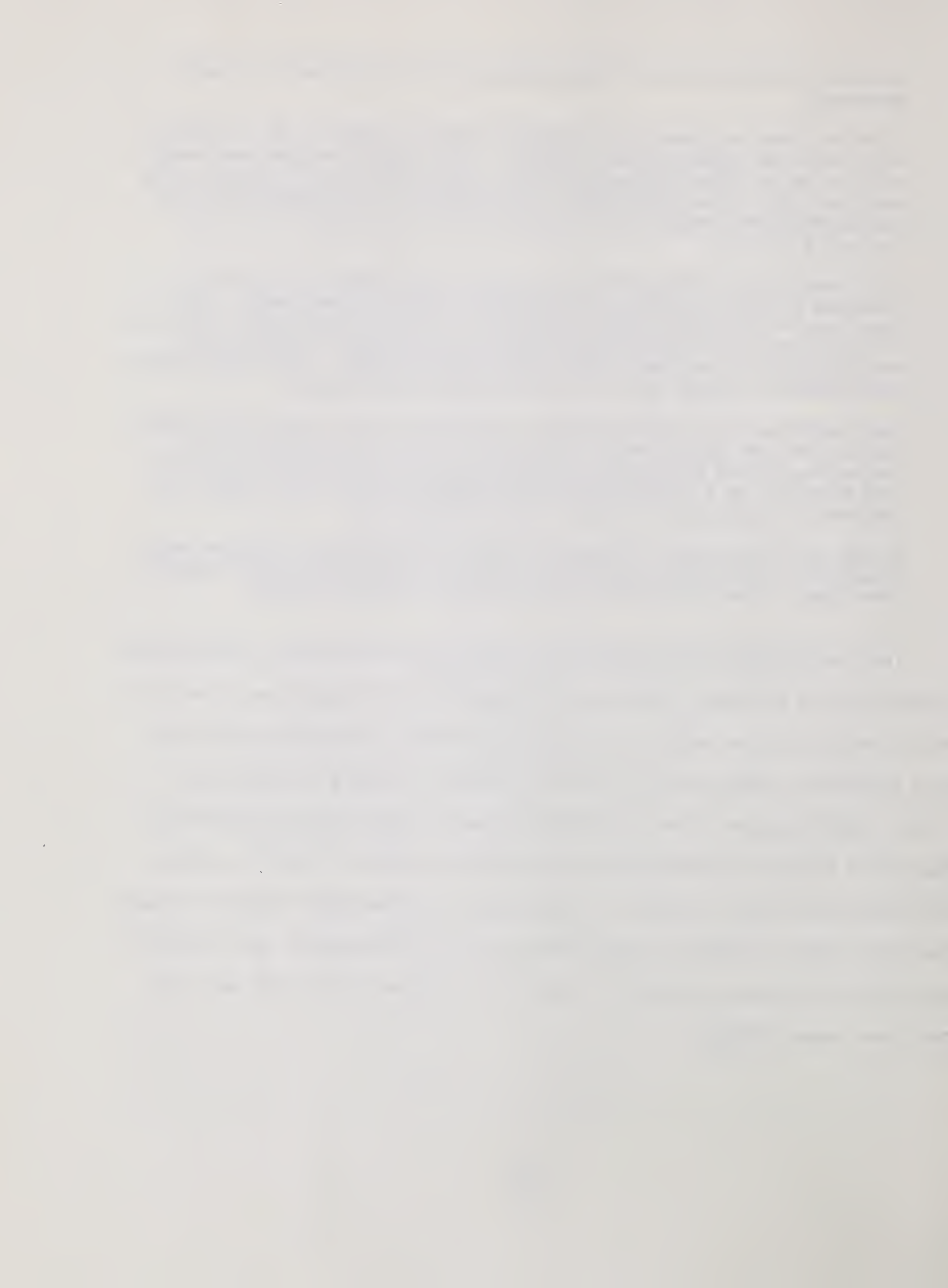
A second alarm was ordered by the Deputy Chief en route to the fire and a third alarm was requested upon arrival. Fire fighters encountered smoke and fire in the front stairway and heavy smoke in the rear stairway. They made their way to the second floor with difficulty, encountering fire at the second-floor landing with the north side of the second floor fully involved with fire.

With visibility at zero on the third floor, fire fighters using self-contained breathing apparatus located four victims in two rooms. One of those four victims was located in a closet. Two victims located in Room 10 on the second floor were the last found. The seventh victim died as a result of falling or jumping from a third-floor window. One other occupant was critically injured and five fire fighters were injured.

Additional hose lines were advanced to second and third floors over ground ladders and from aerial towers. Once the fire on the second floor was knocked down, fire fighters who had entered the front reduced their 2 1/2 inch hose line to a 1 1/2 inch line and advanced to the third floor and continued fighting the fire until it was extinguished.

Of the seven fatalities, the cause of death was reported to be from smoke inhalation in all cases except for the person who jumped or fell from the third floor. None of the fire fighters were seriously injured.

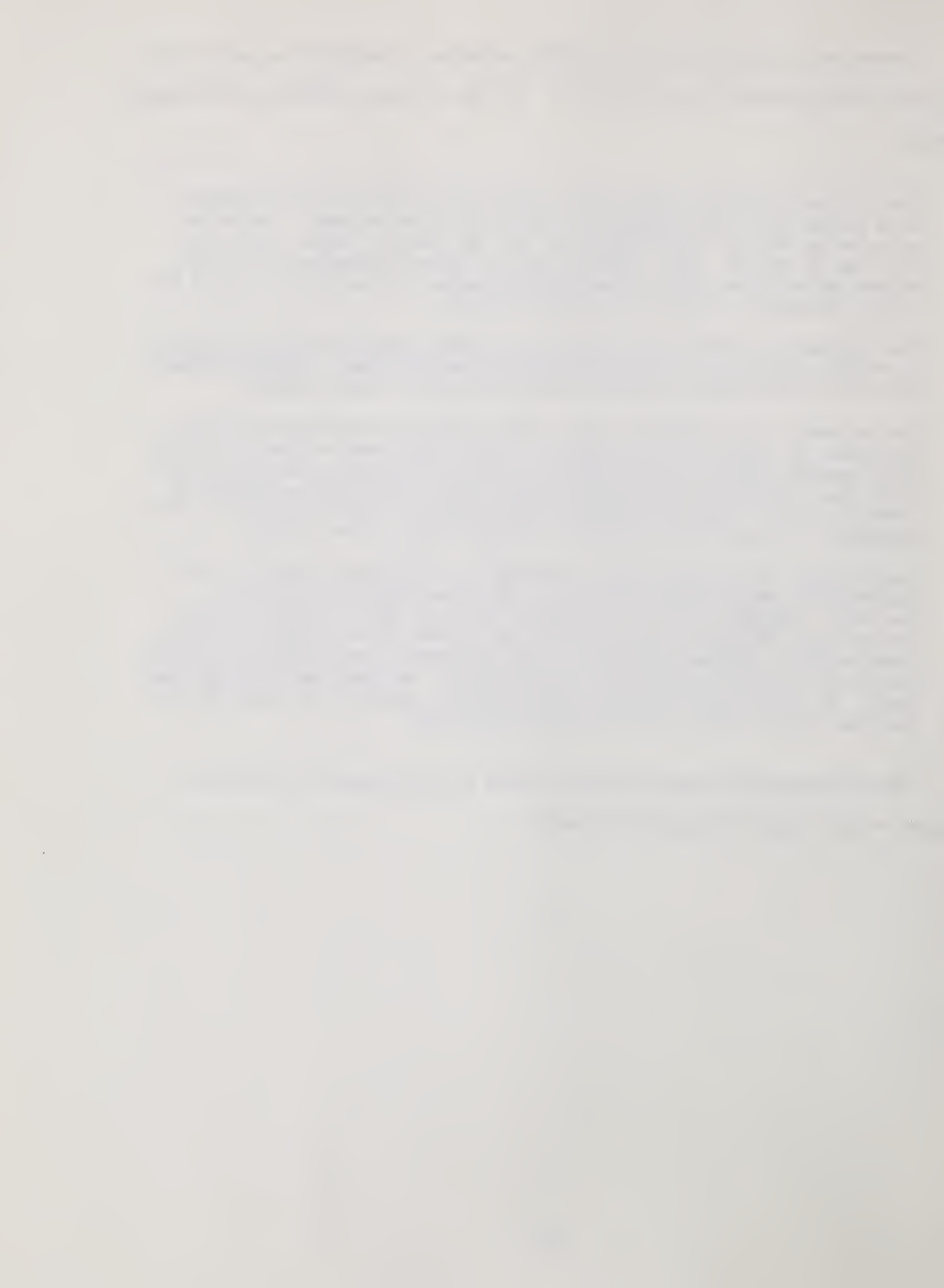
The investigators from the Offices of the State Fire Marshal, the Worcester County District Attorney's office, and the Worcester Fire Department agree with NFPA's conclusion that the fire at CCH was accidental, and caused by the careless disposal of smoking materials by the occupant in Room 9 on the second floor. While there was some initial disagreement between the Worcester Fire Department and other investigators on the point of origin of the fire, these differences were later resolved. Investigators confirmed their findings through laboratory tests, studies of evacuation paths, and interviews of the residents, including the occupant of Room 9. Interviews conducted by the EOHS team also confirmed these findings.

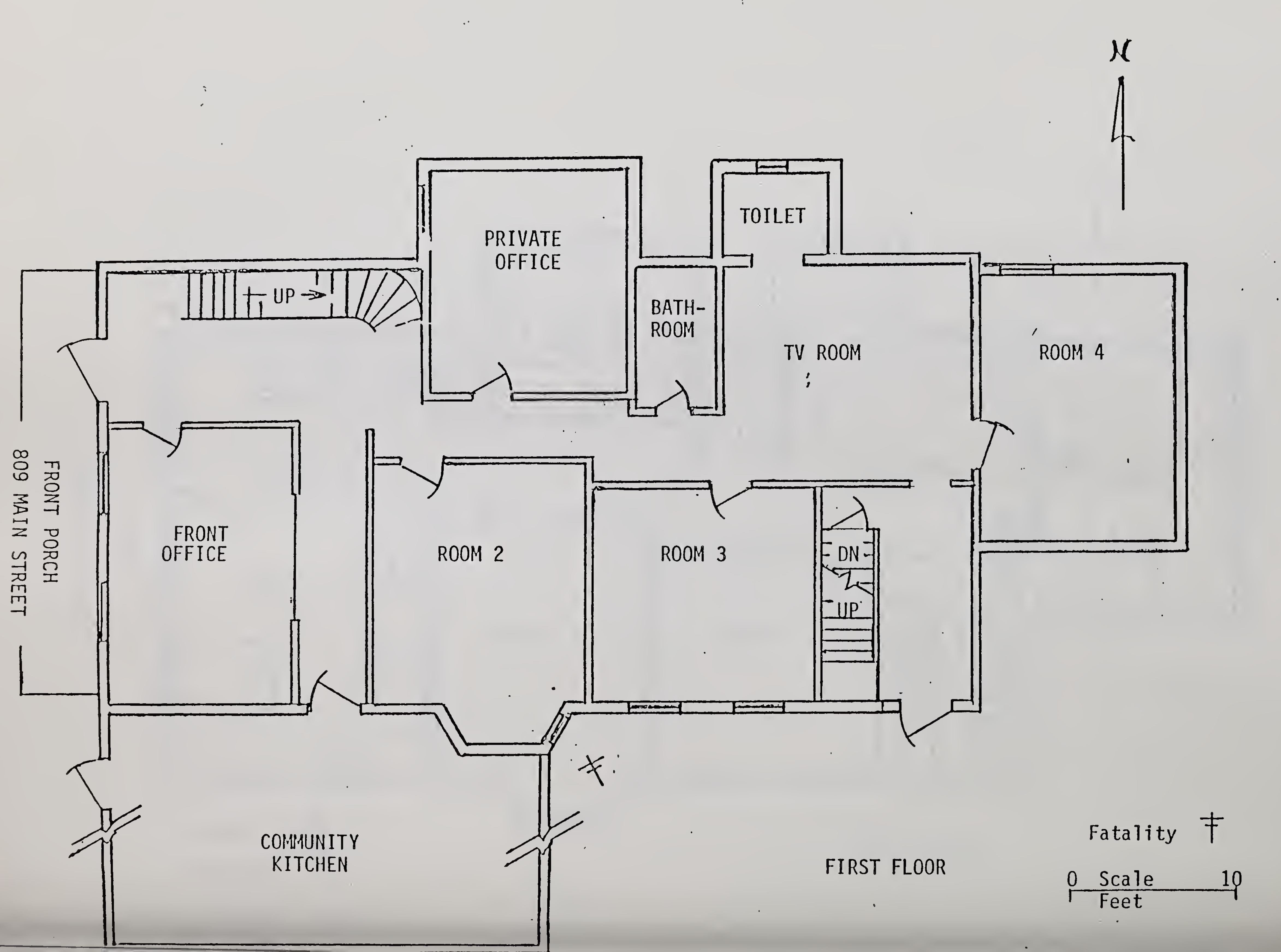


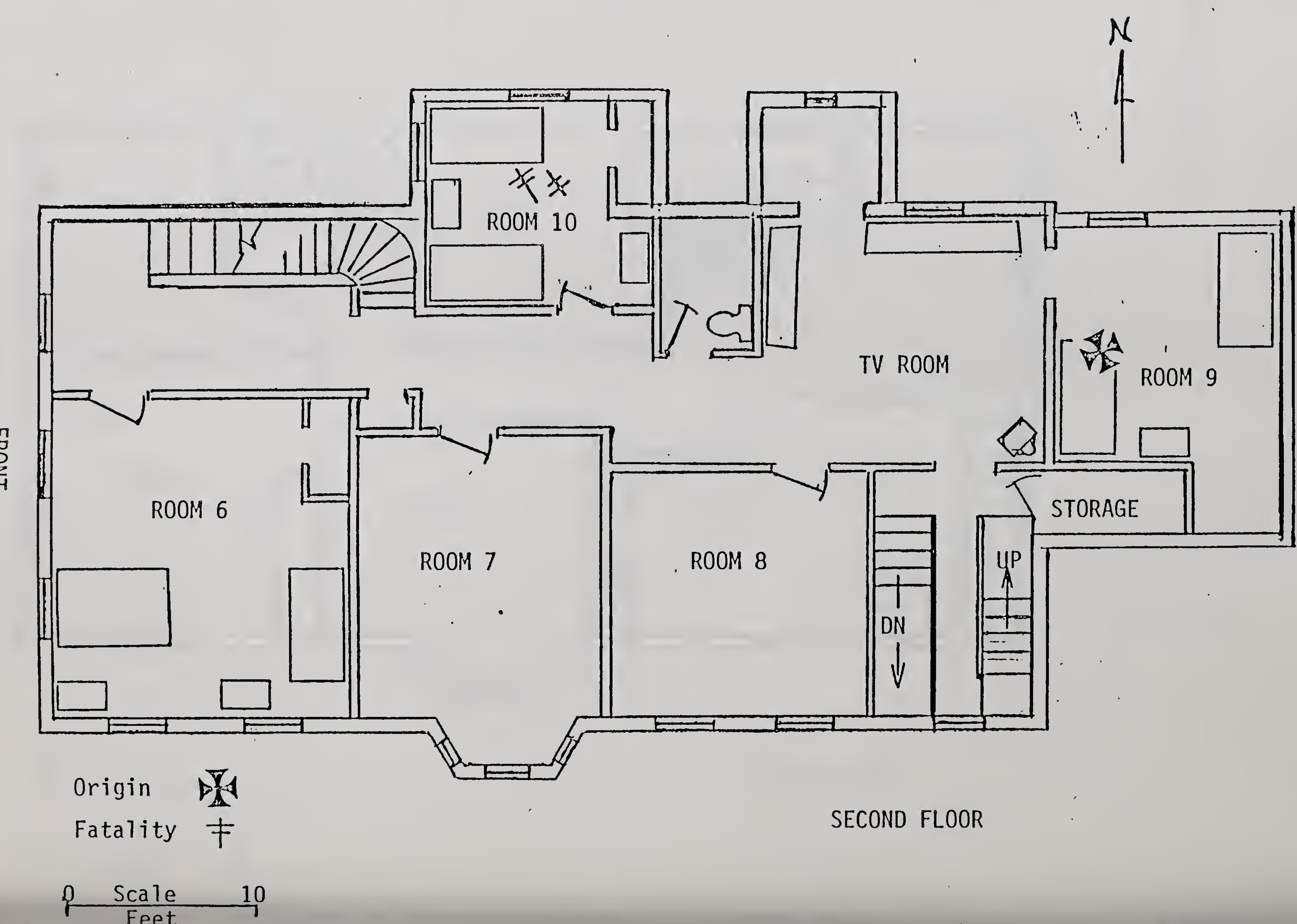
Interviews of the building's residents produced a consistent account of the actions of the occupants during the fire. The NFPA report provides the following summary:

> Most of the residents reported that they were awakened by the building fire alarm. All five occupants on the first floor escaped. Interviews were conducted with two occupants of Room 4, the rear (east) room, below the room of origin. Both reported hearing unusual dragging or rolling noises on the floor above. One reported seeing fire on the railing of the front stairway as she left by the front door.
>
> Two occupants of the second floor died in their room near a bed on the outside wall of Room 10. All other occupants on that floor were interviewed by the fire department and reported leaving by the front stairway.
>
> The occupant of the room of origin, after dragging his mattress to the bathroom, ran down the front stairs. He was later seen on the first floor by a passerby who had entered the building to arouse the occupants. The other four residents on the second floor were awakened and exited by the front stairway. Only one reported seeing flames. He had looked toward the bathroom as he entered the hallway and saw flames in the doorway.
>
> One occupant of the third floor attempted to use the rear stairs. The stairway was smoke filled and he used the front stairs to leave the building. Another third floor occupant reported that he heard the alarm and encountered smoke, but was able to exit from the building using the front stairs. The only other surviving occupant of the third floor heard the alarm and saw heavy smoke in the corridor. He could not wake his roommate. He saw flames coming up the stairway and jumped from the window at the rear to the roof of the rear (east) addition.

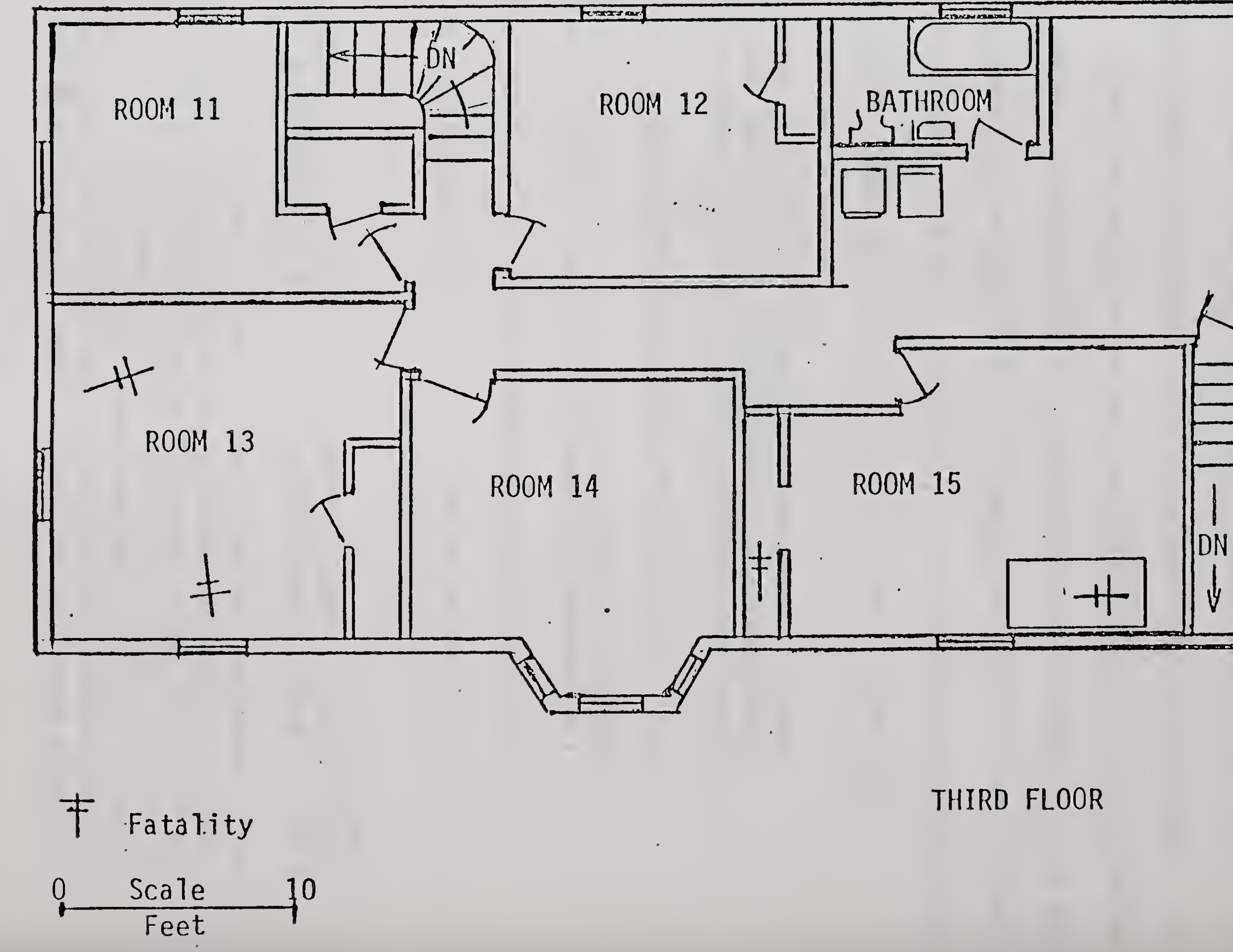
The following three pages, marked Figures 1-3, are plans of the three floors of CCH, taken from the NFPA report:




N
PRIVATE OFFICE
TOILET
UP
BATH-ROOM
TV ROOM
ROOM 4
FRONT PORCH
809 MAIN STREET
FRONT OFFICE
ROOM 2
ROOM 3
DN
UP
COMMUNITY KITCHEN
FIRST FLOOR
Fatality
0 Scale 10
Feet



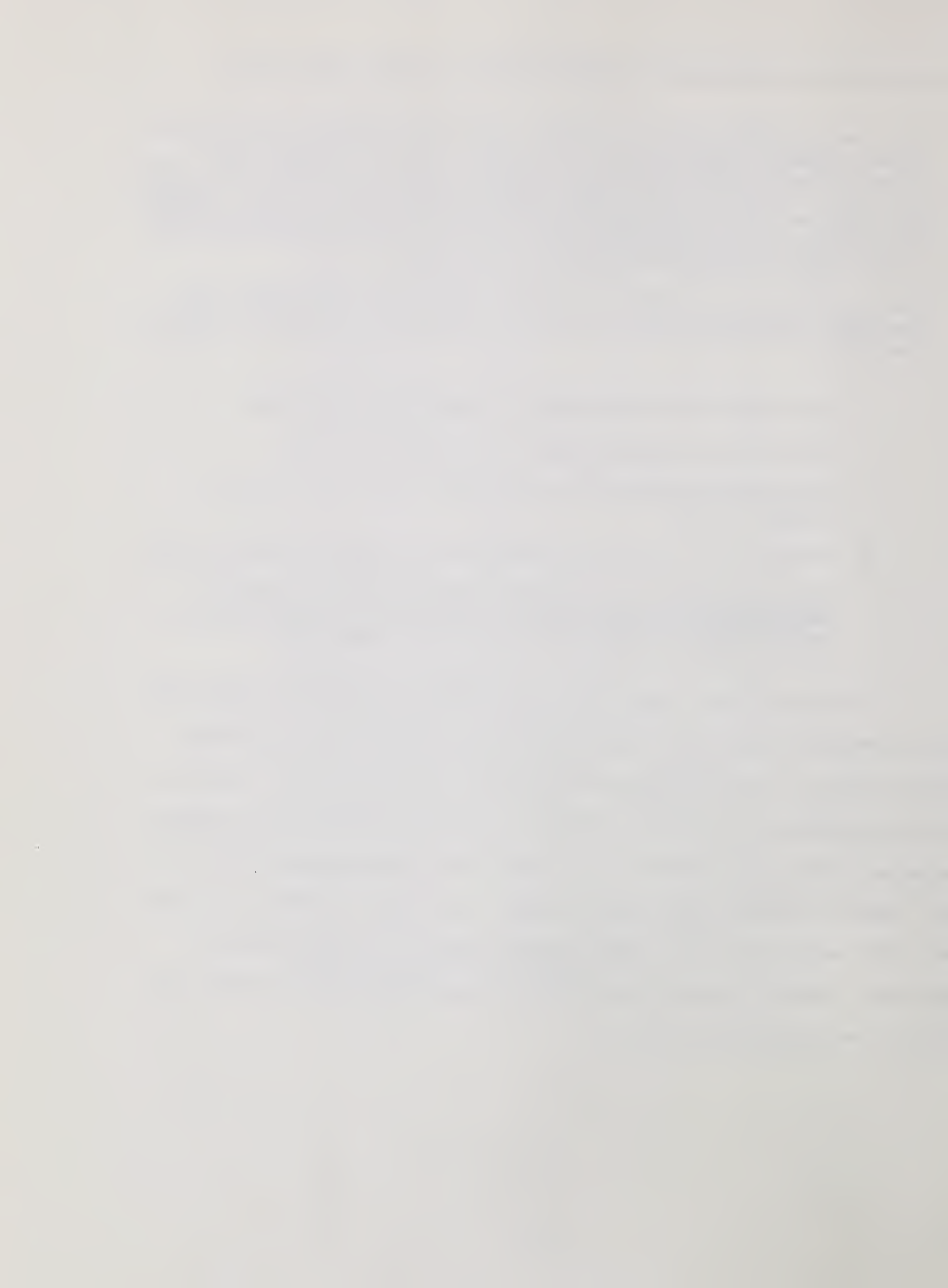
SECOND FLOOR


N
MAIN STREET
FRONT
ROOM 11
DN
ROOM 12
BATHROOM
ROOM 13
ROOM 14
ROOM 15
DN
THIRD FLOOR
Fatality
0
Scale
10
Feet

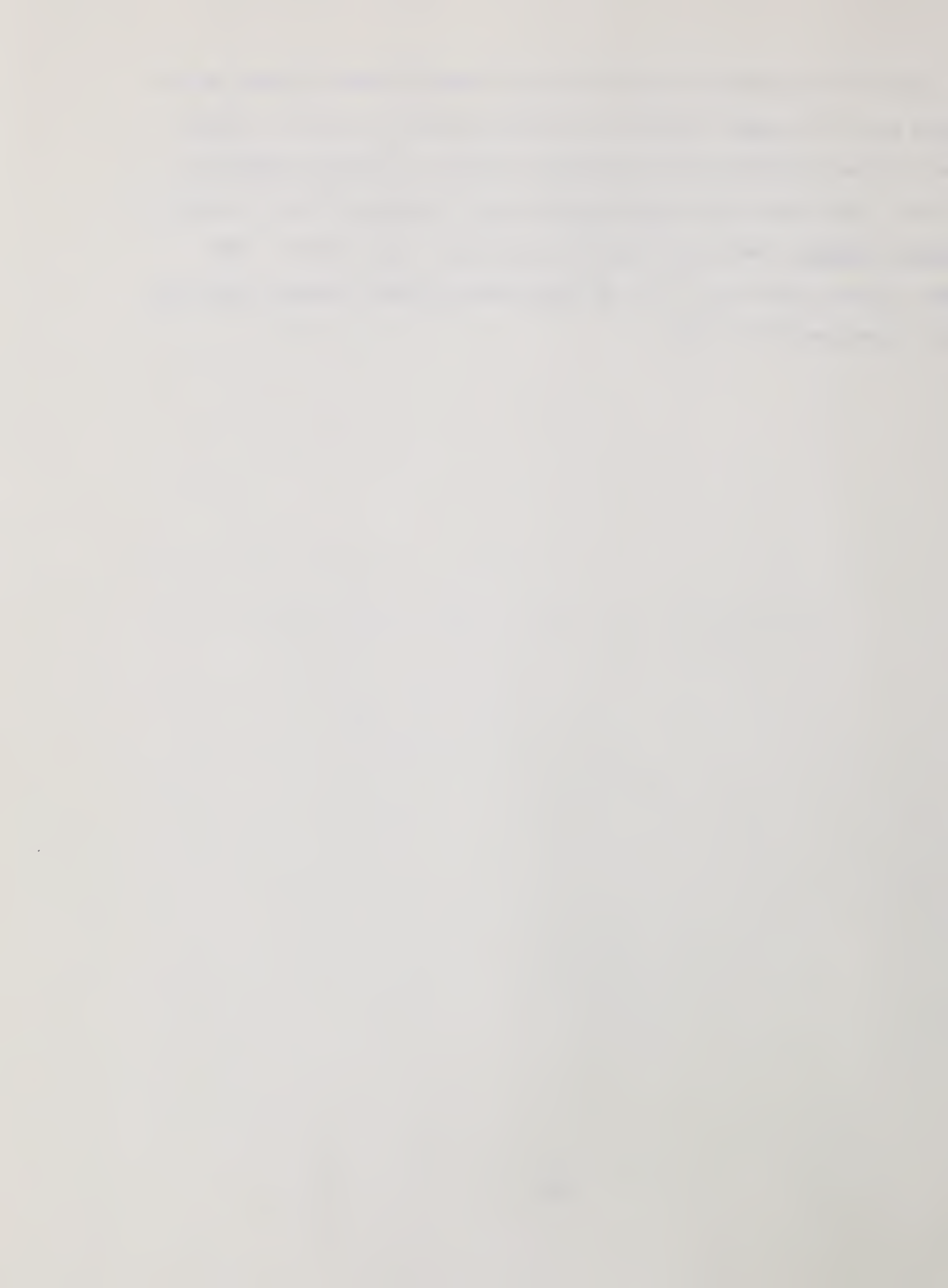
The investigation conducted by the NFPA draws the following conclusions:

> The smoke detection and alarm system in the Central Community Home did not provide adequate protection for the occupants, given the combustible interior finish, inadequate means of egress, lack of compartmentation, lack of sprinkler protection, and lack of supervision in the facility. Although the occupants were apparently alerted early to the fire, they did not have time to escape from the building before existing access corridors and the exits themselves became untenable due to the fire.
>
> Based on NFPA's investigative study, the following are considered to be the major contributing factors to the loss of life in the Central Community Home fire:
>
> 1. Stairs were not enclosed with fire barriers or protected.
> 2. The fire was not extinguished in its incipient stage.
> 3. The presence of combustible interior finish in exits and exit access corridors.
> 4. Fire exit drills were not conducted at the Central Community Home.
> 5. There was neither a direct fire alarm connection to the fire department nor a staff person on duty when the fire occurred to provide immediate notification to the fire department.

Although a few of the 14 surviving residents stayed with friends and family immediately after the fire, most of the survivors moved to two other lodging houses in the neighborhood that belong to the owner of CCH. Staff at WSH and the CMHC who were familiar with the residents stayed at these rooming houses during the days after the fire to help the residents cope with the crisis. Many WSH and CMHC administrators spoke of the dedication shown by direct care staff during this time. Other community agencies, including Catholic Charities, the Red Cross, and the Salvation Army, provided food and other services to the displaced residents.



Many of the surviving residents of Central Community Home said they wanted to move back to the home, and about one month after the fire, eight residents moved into the first floor of the building, which was not severely damaged by the fire. One resident, who helped evacuate others during the fire, told the Worcester Telegram, "We're thrilled to be back here. This is home." Other former residents moved back to the building after the owner finished renovations of the second and third floors.



VII. WORCESTER STATE HOSPITAL - FINDINGS AND DISCUSSION

A. Introduction

All of the residents of Central Community Home who had been patients at Worcester State Hospital (WSH) had been assigned to the Greater Worcester Unit (GWU). To assess the discharge decisions for these residents as identified in the scope of the investigation, the EOHS team reviewed the hospital records for each resident, interviewed administrative and direct care staff on the Greater Worcester Unit, and reviewed policy and procedure manuals, organizational plans, and special reports and studies of the Worcester State Hospital.

In the course of its assessment of discharge decisions, the EOHS team also looked at other aspects of the GWU, including the treatment received by patients and the physical condition of the unit.

B. The Environment, Staff, and Treatment on the Greater Worcester Unit.

FINDING:

TREATMENT ON THE GREATER WORCESTER UNIT WAS AFFECTED BY HIGH CENSUS LEVELS, LOW STAFFING LEVELS, AND THE UNIT'S INSTITUTIONAL CHARACTER; TREATMENT CONSISTED PRIMARILY OF CRISIS INTERVENTION, STABILIZATION THROUGH MEDICATION, AND CUSTODIAL CARE.

The only building that currently houses patients at Worcester State Hospital is the Bryan Building, an eight-story brick structure built in 1957. A 1980-81 Brandeis University study entitled "The Future of Worcester State Hospital and of Public Mental Health Care in Central Massachusetts" described the Bryan Building in the following words:

Although of relatively recent construction, the facility is nevertheless very similar to public institutions that were built at the turn of the century. Each ward contains several multibed bays opening to a long corridor. In spite of valiant efforts by the staff to maintain a clean and colorful environment, the sparsely furnished, tiled, institutional character of the facility is striking. Private space is at a premium, and the lack of adequate indoor and outdoor recreation facilities is a problem.

There appear to be very few people (if any) who believe that the Bryan Building is a suitable place for people to live or be treated for an illness. Staff within the facility point to the need for space for physical activity and enclosed outdoor spaces for clients who must now remain on locked wards.

In an April, 1983 memo, the DMH Worcester Area Director wrote, "One of the most significant inpatient problems is that the unit remains housed within a hospital built in another day for another purpose." And in a June, 1983 report to the Worcester Area Board, he wrote: "Part of the problem faced by the mental health system is not so much a lack of resources as it is their inappropriate distribution. Too much of the money allocated to Worcester State Hospital must go into the operation and maintenance of an antiquated and too large physical plant."

As mentioned earlier, WSH lost its Medicaid certification partially due to deficiencies in the physical plant.

The Greater Worcester Unit is divided into four residential wards--two admissions wards, one long-term care ward, and one forensic ward. A separate psychiatrist is assigned to each ward. The physical capacity of each ward is 25, although the forensic ward, which consists of court-assigned patients, has a census cap of 15. Thus, the total capacity of the GWU is 90 patients.

According to statistics supplied by the Area Office, and confirmed by site visits and in many interviews with unit administrators and direct care staff,

the GWU is consistently above its capacity and overcrowded. The average monthly census of the unit for the six month period between February and July of 1983 was 107.5, 17.5 patients above the unit's capacity of 90. In addition, because the forensic ward is often below its capacity of 15, and because the unit tries to maintain a steady census on the long-term care ward, the unit's two admissions wards, 5C and 6C, are particularly crowded. Built to house only 25 patients each, the wards each carried a census range from 34 to 49 patients during that same six month period. Patient beds on these wards are lined up almost touching each other in open co-ed bays.

In addition to the crowded conditions, staffing patterns are significantly below Department of Mental Health guidelines of 1.3 to 1. For the same six month period, the staffing pattern on the Greater Worcester Unit was .97 to 1, based on 104 staff for 107.5 patients. Despite the difficult environment on the GWU, staff displayed a genuine commitment to the welfare of the patients. Many spoke of the inadequate services for patients both inside and outside the hospital and their hopes for improvements in the mental health system.

In response to the census problems, the Greater Worcester Unit has recently opened a new unlocked 20-bed "dormitory ward" that will house some of those patients who do not need hospital levels of treatment but who are waiting for residential placements in the community. The ward will be staffed at a less intensive level than other hospital wards by employees transferred from the Regional Unit, and therefore will not take staff away from other wards on the GWU.

Although some efforts are made to involve patients in group therapy sessions and day activities, the EOHS team found that treatment on the GWU primarily consists of crisis intervention, custodial care and stabilization through

medication. All hospital staff spoke of the difficulty in providing meaningful treatment at the hospital. Some patients receive treatment in community settings in preparation for their discharge. This includes day passes to group sessions at a CMHC day program and trips to a shelter in Worcester.

Medical records of the 21 former WSH patients who were registered at the CCH at the time of the fire reflected comments made by hospital staff in interviews. Although there are frequent nursing notes that focus on patient behavior, there was no description of patients participating in group or individual sessions. There was only a rare mention of a patient attending activities therapy.

C. Discharge Decisions on the Greater Worcester Unit

FINDING:

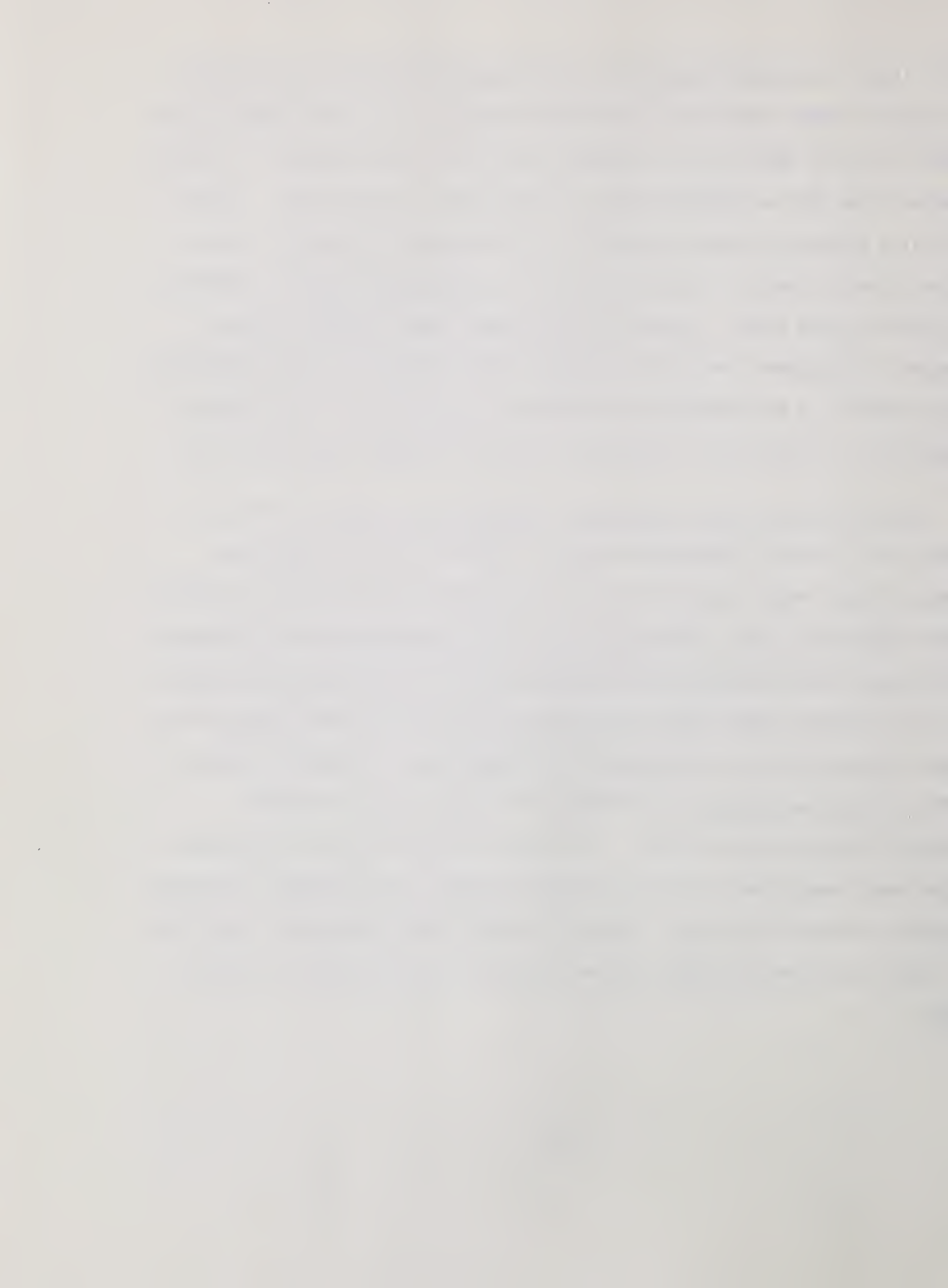
DMH DOES NOT HAVE CLEAR POLICIES OR STANDARDS TO GUIDE DISCHARGE DECISIONS BY HOSPITAL CLINICIANS. ONE RESULT OF THE ABSENCE OF SUCH POLICY WAS THAT SOME PATIENTS WERE KEPT IN THE HOSPITAL LONGER THAN IS CLINICALLY APPROPRIATE WHILE OTHERS WERE DISCHARGED INTO SETTINGS THAT MAY HAVE BEEN INAPPROPRIATE AND UNSAFE.

Many GWU staff spoke of the absence of any clear indication from DMH Central, District, and Area Office administrators about what discharge policies should be pursued. The EOHS team found that there were no real standards for discharges on the GWU, but simply individual decisions that were based on a variety of factors.

Interviews with psychiatrists, unit administrators, social workers and psychologists did reveal an informal process of categorization of GWU patients into two discrete populations for purposes of discharge. According to hospital

staff, there is one patient population in the hospital who tend to be kept at the hospital longer than their clinical needs require. This first group is composed of patients whom the staff believe need, and will be successful in, structured settings such as halfway houses, nursing homes, and rest homes. Because there is a shortage of such placements in the Worcester area, however, these patients tend to remain at the hospital until an appropriate space is available. The hospital staff takes a cautious attitude about these patients; they are reluctant to discharge them into an unsupervised setting if a future opportunity for placement in a more appropriate residence is expected. It is this type of patient who is likely to be transferred to the newly-opened "dormitory" ward.

There is another group of patients in the hospital that GWU staff also believe are in need of supervised settings. Members of this second group, however, either refuse to be placed in such structured settings, have a history of not succeeding in such settings, or will not be accepted into such settings. It is these patients, many hospital and CMHC staff believe, who are discharged into the community without adequate discharge planning, and into settings which do not include the level of supervision that they need. In addition, hospital staff said that the pressure to discharge this second group of patients increases with high census levels. Interviews with GWU staff also indicated a belief that these clients were less likely to benefit from available residential programs than the first group. Hospital and CMHC staff consistently identified the majority of Central Community Home residents as falling into this second group.



D. Discharge Planning on the Greater Worcester Unit

FINDING:

DISCHARGE PLANNING AND THE DEVELOPMENT OF AFTERCARE PLANS WERE INADEQUATE, MINIMALLY RECORDED, AND DID NOT INCLUDE ASSESSMENTS OF A VARIETY OF SKILLS, INCLUDING SELF-PRESERVATION AND DAILY LIVING SKILLS.

According to interviews with hospital staff, discharge planning at WSH begins as soon as a patient is admitted to the hospital. Each patient is assigned to a social worker, who gathers information on the patient, and begins to plan for discharge when the client is sufficiently stabilized to return to the community. No separate discharge planning conferences are held, but discharges are discussed by the clinical team at regular ward meetings. All discharges must ultimately be approved by the ward psychiatrist.

Although hospital staff said that discussion of discharges is a regular part of ward meetings, there was little or no documentation of discharge planning in the records of patients who later lived at Central Community Home. There was no documentation of a clinical assessment of the level of supervision in the community required for each patient, or of the patients' ability to care for themselves or to manage money, or of testing of the patients' self preservation status. Some patients were discharged a short time after nursing notes described them as "agitated", "hostile", "hallucinated." Although the condition of such patients may have changed prior to discharge, there was no documentation of such changes. The records indicated that one patient was severely agitated and fearful whenever there was a fire alarm drill, and that another was unable to use the telephone to aid in his own rescue from a malfunctioning elevator. There was no documentation that these conditions had improved at the time of discharge. In general, the lack of documentation made it difficult for the EOHS team to determine the condition of patients at the time of discharge.

DMH staff explained that unlike the elaborate practices of the DMH mental retardation system, the state's mental health system does not regularly test or train clients in self-preservation skills. Community placements, therefore, are made without an objective measure of a patient's ability to leave a building during a fire within a specified period of time. Almost all GWU staff said this would be a valuable resource for making discharge decisions and community placements. Other DMH staff pointed out, however, that such self-preservation testing is difficult because of the dynamic nature of mental illness, and that fire safety training should be specific to the setting to which people ultimately move.

According to GWU staff, patients are discharged when the clinical team -- which consists of a nurse, social worker, psychologist and psychiatrist -- believes that the patient is clinically ready, and when an appropriate residence is found for that patient. In addition, patients who are in the hospital on a voluntary basis may exercise their right to give a three-day notice to the hospital indicating that they wish to be discharged. This notice may be opposed by the staff if they believe that a patient's condition is such that he or she presents a danger to him or herself or to others.

E. Use of Extended Visit

FINDING:

GWU PATIENTS LIVING IN THE COMMUNITY ON EXTENDED VISIT STATUS WERE NOT TREATED OR MONITORED BY GWU STAFF, NOR WERE SPECIAL EFFORTS MADE BY THE GWU TO ENSURE THAT THESE PATIENTS WERE SEEN BY CMHC STAFF.

The GWU regularly practiced a policy of not formally discharging certain patients that they believed would require readmission. Instead, these patients were released into the community on Extended Visit (EV) status. Under this practice, the patient continues to have inpatient status, although he or she

resides in the community. If a patient on EV presents him or herself at the hospital and readmission is determined to be clinically appropriate, many admissions requirements are obviated. Readmission then terminates the EV status.

Hospital staff did not regularly monitor the condition of a patient on EV in the community. They assumed that any such monitoring would be performed by the clinician assigned to the client from community agencies, although they made no special efforts to ensure that this occurred. Under DMH regulations, the patient would be formally discharged from the hospital one calendar year from the date last released on EV, if there were no returns to the inpatient unit within that period. No official check of the patient's status would be done by GWU staff prior to such a discharge.

Two other DMH areas surveyed by the investigative team used EV more conservatively than GWU, reserving it for unusual circumstances. These areas limited the maximum EV period to a few months and conducted regular reviews of the patient's status during the period.

Most of the 21 former patients of Worcester State Hospital who were registered at Central Community Home at the time of the fire had at one time been released on EV. Six of these residents, including one of the deceased, were on active EV status on the day of the fire.

F. Discharge Coordination with the Community

FINDING:

THERE WAS INSUFFICIENT COORDINATION OF DISCHARGE AND AFTERCARE PLANNING BETWEEN THE GWU AND THE CMHC.

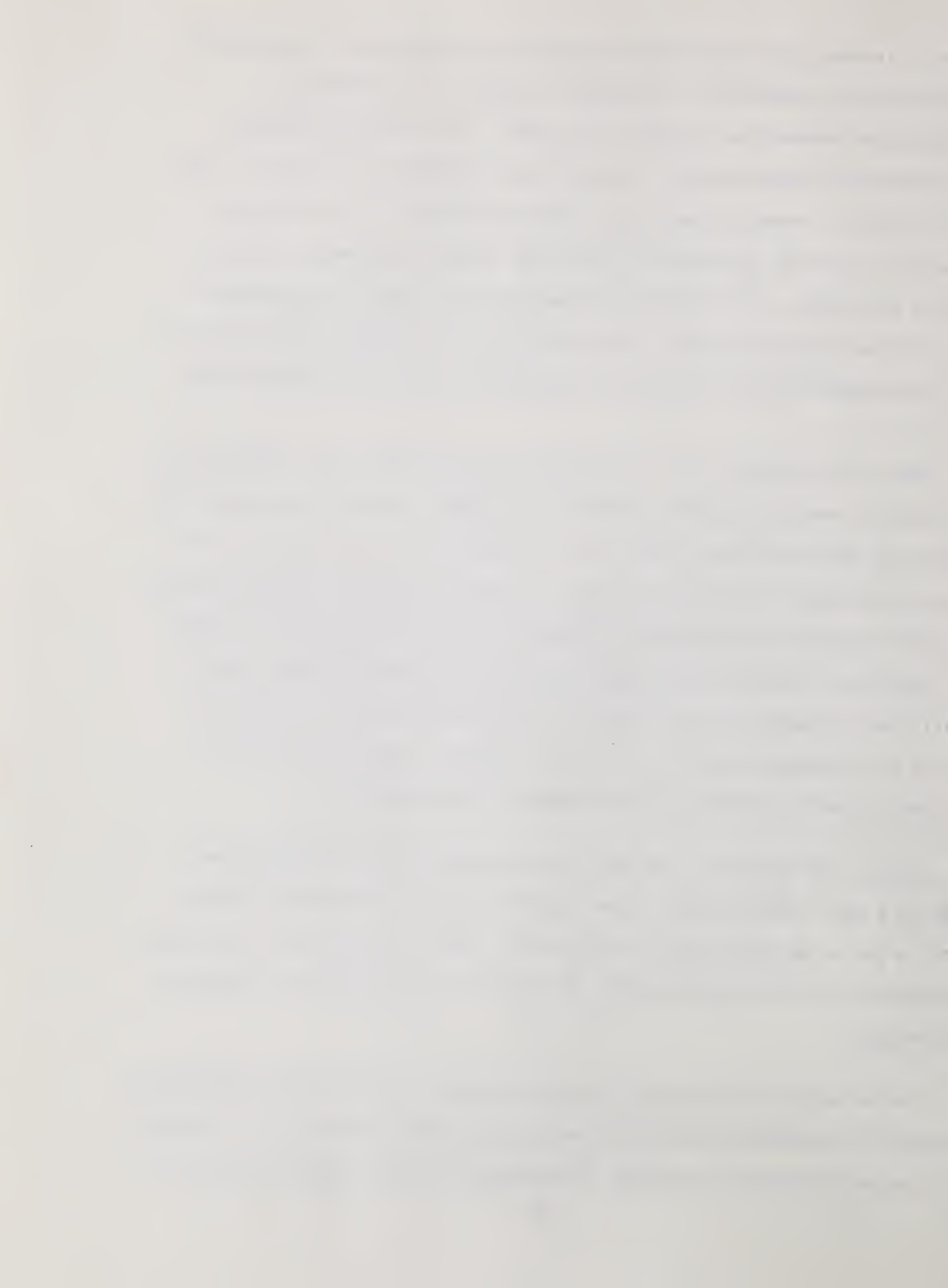
Once discharged from the hospital, each patient is assigned a primary clin-

ician at the Worcester Area Community Mental Health Center who is responsible for coordinating each patient's aftercare treatment in the community. Communication between the hospital and the CMHC occurs through a hospital employee who has been assigned to the CMHC and designated as a liaison. There is also regular informal communication between hospital social workers and aftercare clinicians, particularly concerning community placements and readmission of patients. Other efforts at coordination include the attendance of CMHC clinical directors at GWU clinical meetings, and the joint appointment of the same person as medical director of the CMHC and clinical director of the GWU.

GWU staff explained that once patients are discharged, their responsibility for patients ends and the CMHC responsibility begins. According to records and interviews, CMHC clinicians rarely visit clients while in the hospital, and rarely participate in discharge planning. Similarly, GWU staff rarely check on patients once they are discharged. Both CMHC and GWU staff spoke of the need for such joint discharge and treatment planning, but both said other responsibilities precluded CMHC participation in hospital activities, or GWU monitoring of discharged patients. A previous practice of CMHC participation in discharge planning meetings was considered too time-consuming.

Notice from the GWU to the CMHC of discharges of patients ranges from a week to a day, and occasionally, CMHC workers are not notified of discharges until a day or two after the discharge occurs. CMHC clinicians interviewed consistently stated that they are often not given sufficient notice of impending discharges.

Social workers at the hospital have the primary responsibility for locating residential placements for patients who are discharged from the GWU. A shortage of structured residential settings in the Worcester area, however, results in a



limited number of options. There are long waiting lists for DMH-funded community placements, and active competition for the beds which become available in nursing homes and rest homes.

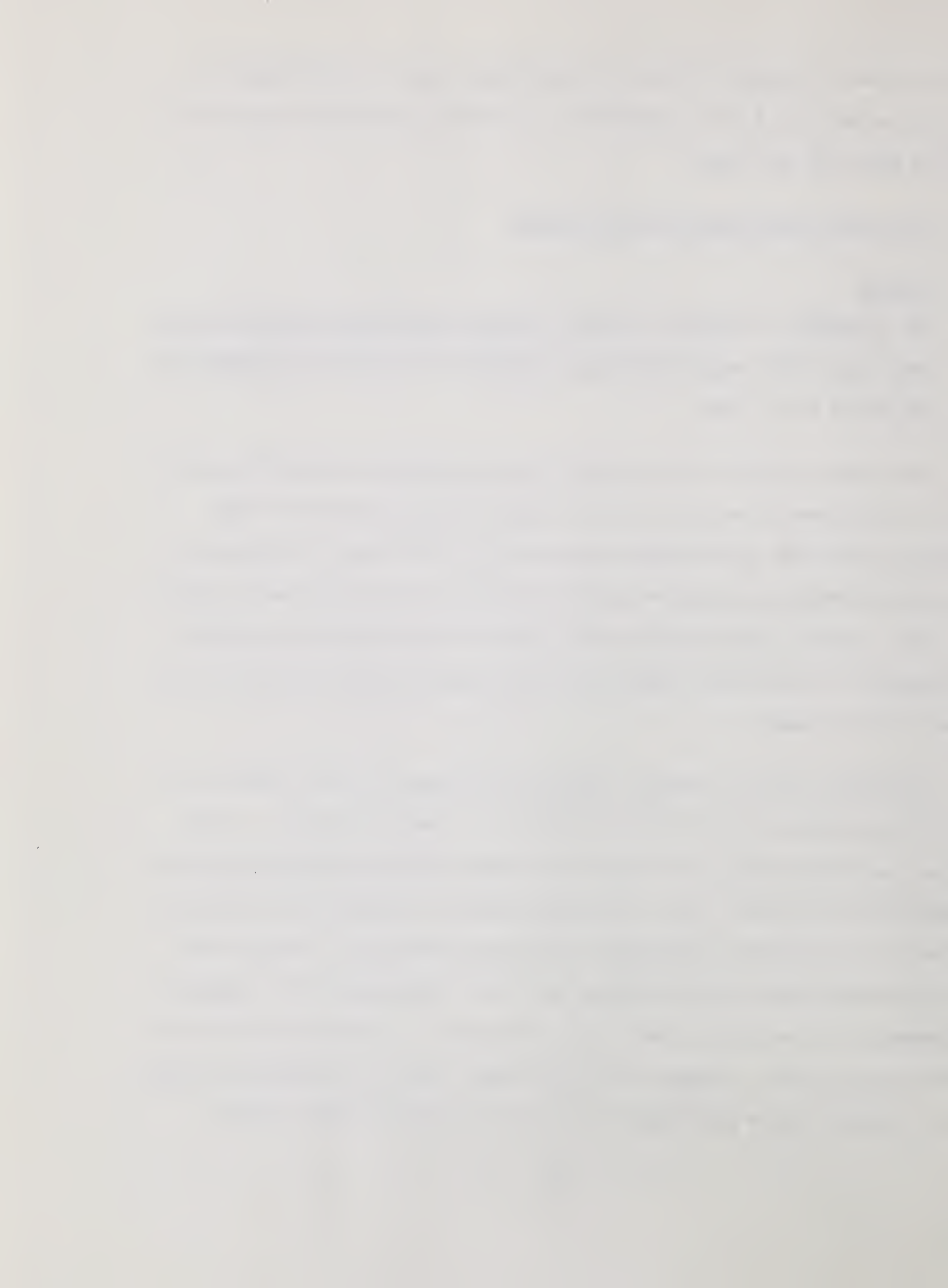
G. Relationship with Central Community Home

FINDING:

THE DISCHARGE OF PATIENTS TO CCH WAS A REGULAR AND ACCEPTED PRACTICE ON THE GWU AND WAS OFTEN MADE WITHOUT FULL KNOWLEDGE OF THE LEVELS OF SUPERVISION AND SAFETY IN THE HOME.

Within the available set of choices, Central Community Home (CCH) was and still is considered by GWU staff to be a regular placement option for many patients, preferable to discharging the patient to "the street." Although consistently expressing reservations about the building and its proprietor, hospital staff regularly refer clients to CCH. GWU staff said many of the patients discharged to CCH have lived there previously, request placement there, and consider it their "home".

Placements to CCH are managed like other discharges. Social workers from GWU call the owner or staff of CCH and inquire if a bed is available. If the patient has never lived at the home, social workers often accompany the patient to CCH for a trial visit. On at least one occasion, the owner of CCH visited a patient in the hospital to encourage a discharge to the home. Once the owner and the patient agree to the placement, the social worker begins the necessary arrangements for assistance benefits and the patient is transported or finds his or her own way to CCH. Between one and two weeks' supply of medication is given to the patient, and an appointment is usually set up with a CMHC clinician.



(The owner of CCH owns 10-12 other buildings with varying degrees of supervision in the Worcester area, many of them lodging houses near CCH. Often, when GWU staff contact the owner and inquire about an available room, the owner makes a determination about which of his buildings is appropriate for the patient. He bases this determination on prior knowledge of the patient, if any, and the availability of beds.)

In interviews with the EOHS team, most GWU staff had incomplete or outdated information about CCH. Many believed, for example, that CCH provided consistent night-time supervision, when in fact it did not. Many also assumed there was closer monitoring of the residents' medication.

H. Records

FINDING:

PATIENT RECORDS ON THE GWU WERE SERIOUSLY INADEQUATE.

In addition to the lack of treatment and discharge documentation, the WSH records for the residents of Central Community Home contained other deficiencies:

1. Psychiatric notes were infrequent, related only to medication changes, and rarely specified levels of dosage.

2. There were no recent narrative psychosocial histories or traditional psychiatric evaluations detailing the patient's present illness or past history, nor documentation of mental status exams or psychodynamic formulation.

3. There was no documentation of the patient's attitude towards or participation in his or her treatment plan.

4. No one on the Greater Worcester Unit staff had the clear responsibility for documenting the patient's progress and revising the treatment plan.

5. There was no documentation of regular rounds or planning conferences.

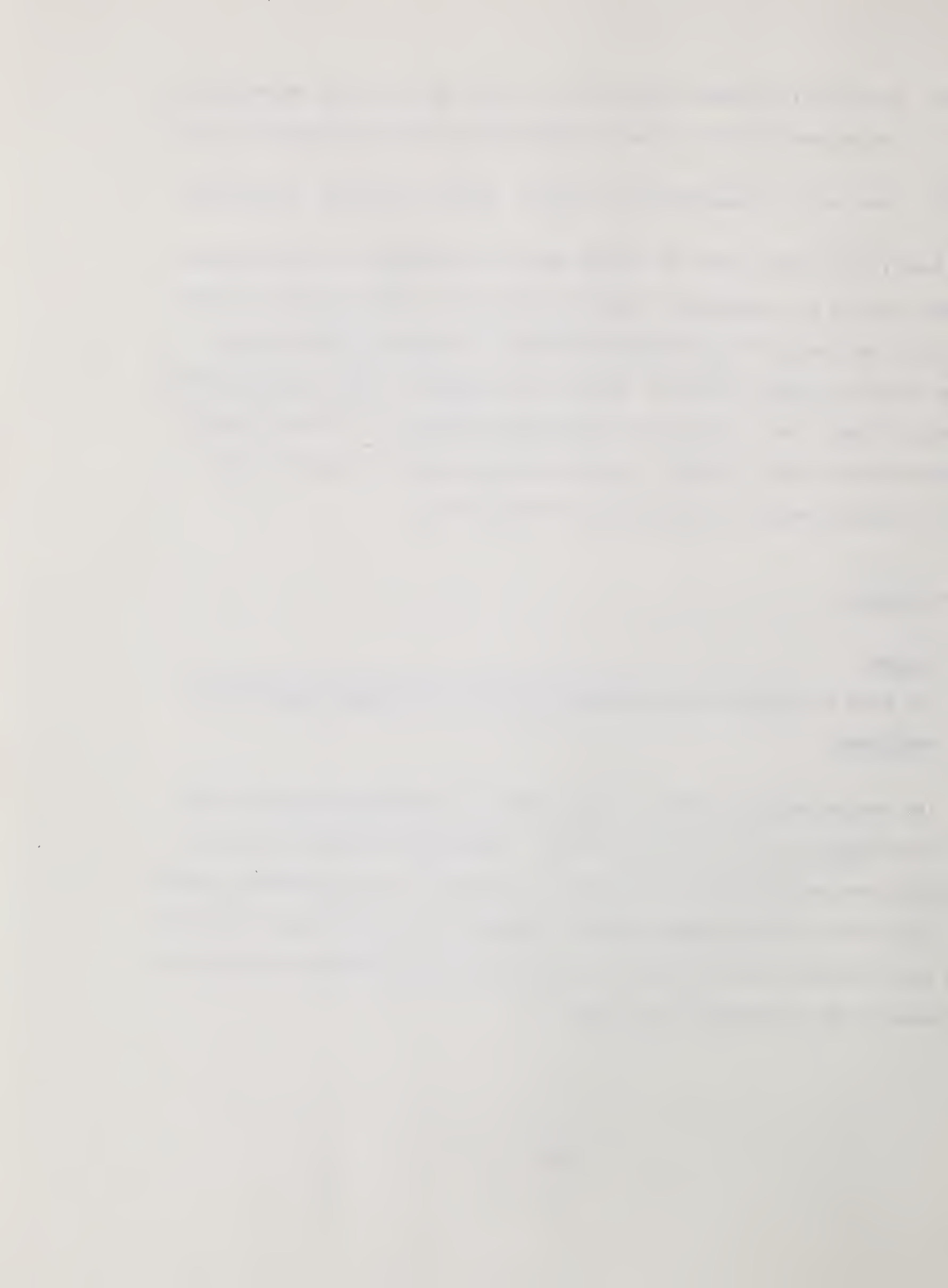
Administrators and staff of the GWU openly acknowledged that documentation was poor and did not adequately represent patient care. Many said that crowded conditions and low staff levels made it difficult to find the time to keep proper records. Recent efforts to overhaul the hospital's entire record-keeping system have begun, and a new "Policy and Procedure Manual for Patient Records" was implemented on May 4, 1983. This new policy is part of a hospital-wide effort to regain Medicaid certification for the facility.

I. Procedures

FINDING:

THE STAFF OF THE GWU DID NOT FOLLOW THE UNIT'S ESTABLISHED POLICIES AND PROCEDURES.

The Greater Worcester Unit does have carefully developed procedures that are incorporated in a social service manual. The manual describes the role of the social worker, and details an extensive procedure for record-keeping, treatment coordination and discharge planning. Reviews of the records and interviews with staff indicate that the manual is rarely followed, and that some staff are not aware of the existence of the manual.



VIII. AFTERCARE -- FINDINGS AND DISCUSSION

A. Introduction

All of the 23 people registered at the Central Community Home at the time of the fire had at one time received community mental health services in the Worcester area, and 21 were current clients of the Worcester Area Community Mental Health Center (CMHC) or one of its affiliates. To assess the nature and extent of the support services provided to these residents, the EOHS team examined the Community Mental Health Center records of each of these clients and interviewed administrative and direct care staff of the Center, and other human service providers in Worcester. The EOHS team also reviewed DMH quality assurance and monitoring reports of the CMHC and policies and procedures of the Center.

B. Community Mental Health Center -- Organization

FINDING:

THE CMHC PROVIDES A RANGE OF SUPPORT SERVICES APPROPRIATELY LOCATED IN THE COMMUNITY WHERE MANY OF THEIR CLIENTS LIVE.

The CMHC is divided into several different departments. The Outpatient Services Department (OPD), located at 152 Chandler Street in the "Main South" Area of Worcester where many clients live, provides case management, therapeutic, and medication services to clients. Each client within OPD is assigned to a primary clinician who assumes resonsibility for that client. OPD is also the primary assessment and referral unit within the Center; all new clients receive initial assessment at OPD. Eight of the people registered at the Central Community Home at the time of the fire were assigned to OPD.

If an assessment indicates that a client needs more intensive services than provided by OPD, the client is assigned to the Community Support Services Department (CSS), which provides a range of therapeutic and rehabilitative services. Twelve CMHC clients registered at the Central Community Home were assigned to this department, which is located at 892 Main Street, also in the Main South area. The CMHC Policies and Procedures Manual states that CSS "operates a consistent treatment philosophy based upon social rehabilitation models and attempts to assist clients in the development of social competency and vocations skills to enable them to live as independent and productive lives as possible." CSS consists of several distinct units:

1. The Gathering Tree- a rehabilitative day center focusing on a range of daily living skills and socialization, primarily provided in a group format.

2. Clinical Unit - out-patient psychiatric services including medication monitoring, crisis intervention, individual and group therapy, and including a special Intensive Services Unit (ISU) for "chronically mentally ill clients with repeated psychiatric admissions."

3. Unicorn's Inn - A residential treatment program.

4. Placement and Community Employment Services (PACES) - worker training and placement.

The CMHC operates several additional programs, including an Emergency Mental Health Services (EMHS) unit. The EOHS team looked primarily at OPD, CSS, and EMHS since they provided the primary aftercare services to residents of Central Community Home.

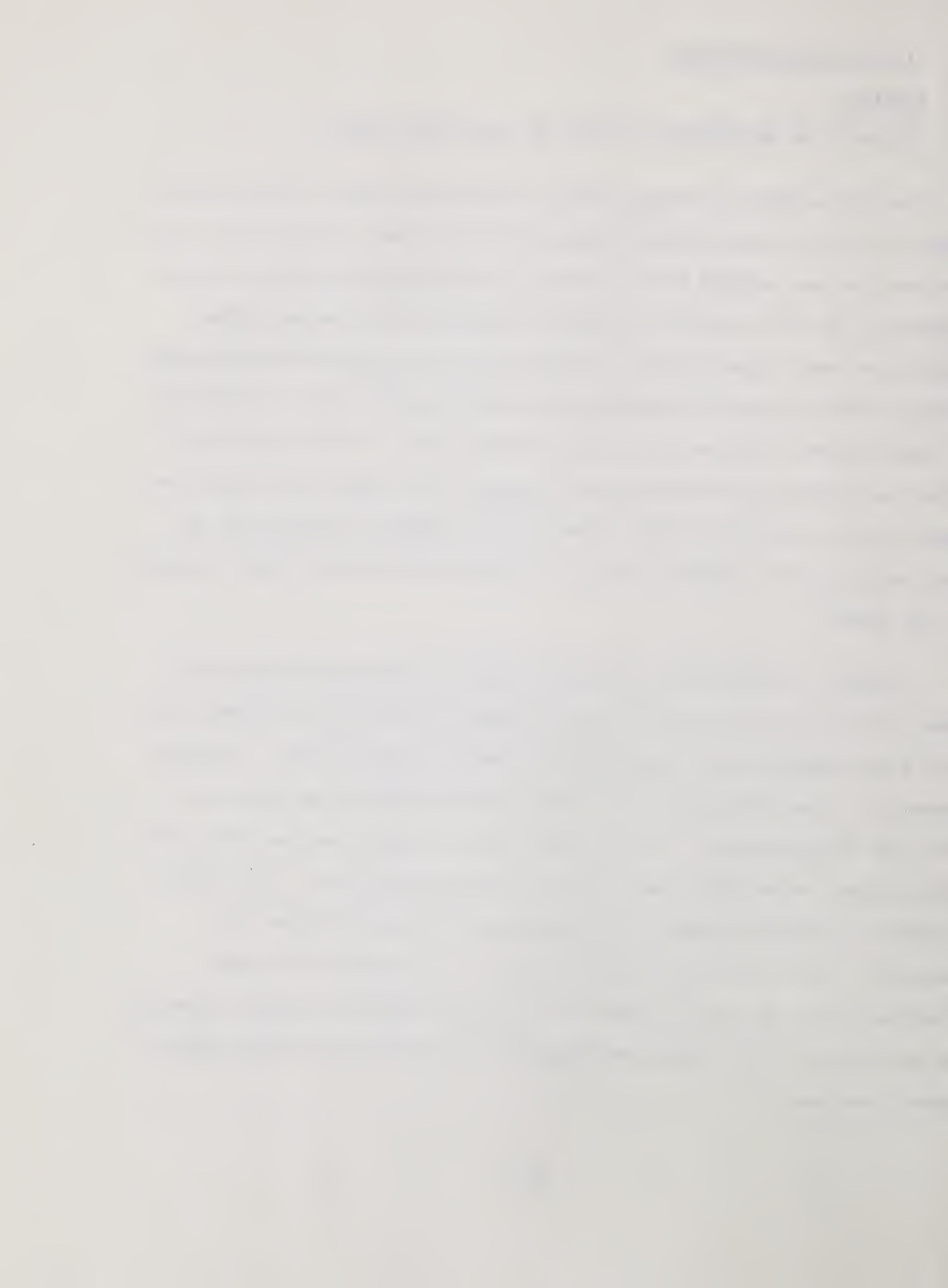
C. Treatment and Monitoring

FINDING:

TREATMENT AND MONITORING OF CLIENTS BY CMHC VARIED WIDELY.

The CMHC attempts to assign clients on the basis of need. Clients who will benefit from the least restrictive program and do not need a broad array of support services are assigned to OPD. Primary clinicians at OPD carry an average caseload of 50 to 60 clients, although at times their caseloads are higher. Clients who need a higher degree of support services are assigned to CSS, where primary clinicians carry an average caseload of 30 to 35 clients. In addition to their primary clinician at CSS, those clients within CSS who need the most intensive aftercare and monitoring are assigned to ISU, whose workers each carry a maximum caseload of 20 clients. Nine of the 12 people assigned to CSS and registered at Central Community Home at the time of the fire were also assigned an ISU worker.

Treatment and monitoring of clients assigned to CSS and OPD vary widely. Some clients are seen almost every day at program activities at the CMHC, while others may repeatedly miss appointments and not be seen for months. The CMHC records of clients residing at the Central Community Home at the time of the fire, for the period April 1, 1983 through June 12, 1983, show one client with 165 contacts, while another had only 10 during the same period. (If a client attends two successive groups on the same day, the record indicates two contacts.) While the level of monitoring usually increased for the most disabled clients who were assigned to the ISU, the numbers of contacts seemed to be more related to the clients' willingness to see staff than to their need for support services.



The majority of the CMHC clients registered at the Central Community Home were described in the CMHC records as frequently regressed, dishevelled, delusional, and/or hallucinating. The records indicated that these clients only occasionally attended appointments, and often had minimal comprehension of or willingness to comply with their treatment plans. According to these records, most of the clients were on medication, although in some cases prescriptions were filled on an irregular basis. The records of some clients indicated frequent adjustments in medications. While all of the clients' records reflected some contact between CMHC clinicians and CCH staff, the records indicate that the clients assigned to the Intensive Services Unit received additional outreach services that included regular home visits and telephone calls to Central Community Home. It should be noted that staff at the CMHC displayed a consistent dedication and commitment to the clients they served.

In interviews, however, CMHC direct care staff often said they were unsure how to serve a population like the CCH residents. They also said that they believed that this population was not receiving the intensity of services it needed. Many staff cited the repeated rehospitalization of some of their clients, as well as the lack of knowledge about how best to treat chronic mental illness, as a measure of the limits of the community mental health system.

Greater Worcester Unit (GWU) statistics for the six-month period from February through July, 1983, show that 82% of the patients admitted had previously been admitted to the GWU. The Worcester Area Director summarized the problem in a June, 1983 report to the Area Board:

We have learned that most chronically mentally ill people do not need hospitalization most of the time, yet we have not yet figured out how to protect the relatively small number of people (I would estimate in Worcester between 100 and 300 in number) who are intact enough to leave the hospital but seriously enough ill to raise appropriate questions about their capability to live adequately in the community.

It was this type of client, most interview subjects said, who lived at Centeral Community Home.

D. Records

FINDING:

DESPITE GENERALLY GOOD DOCUMENTATION PRACTICES, CMHC RECORDS CONTAINED SOME DEFICIENCIES.

All CMHC records contained treatment plans and regular progress notes that described client progress or regression. The records were generally clear and well organized. However, a review of the records of the 21 residents of CCH who were current CMHC clients reveal that:

1. There was no documentation of patient's attitudes towards or investment in treatment plans;
2. There was a noticable absence of traditional psychiatric evaluation and narrative psychosocial summaries that describe clients as people with a past history, and with significant other people in their lives;
3. There was little documentation that treatment programs were available for those clients with a secondary diagnosis of alcoholism.

E. Emergency Mental Health Services and Admissions

FINDING:

THE CMHC SERVICE PRIMARILY RESPONSIBLE FOR CRISIS INTERVENTION AND ADMISSION DECISIONS TO THE GREATER WORCESTER UNIT AT WORCESTER STATE HOSPITAL HAS BEEN MOVED TO A LOCATION LESS ACCESSIBLE TO THOSE WHO NEED ITS SERVICES.

Patients are admitted to the Greater Worcester Unit primarily through the Emergency Mental Health Services (EMHS), a contracted program within the CMHC and located at Worcester State Hospital. The staff of EMHS consists of one LPN, who supervises eight social workers; in addition, a rotating staff of psychiatrists are on call 24 hours per day.

EMHS was located at Worcester City Hospital until January, 1983, when it was moved to WSH after disagreements between City Hospital and DMH/CMHC administrators. City Hospital is geographically located in the Main South Area where the largest concentration of deinstitutionalized clients live and receive aftercare; WSH is located several miles from this area. Immediately after the move, the EMHS monthly statistics dropped from an average of 250 total consultations to 170. A search for an alternative site that is more accessible -- but which can continue to provide the level of backup medical services necessary to meet client needs -- is continuing.

FINDING:

THERE IS A REGULAR GROUP OF AFTERCARE CLIENTS IN NEED OF EMERGENCY MENTAL HEALTH SERVICES.

EMHS staff see people in varying degrees of distress, and use a five page intake/assessment form to evaluate the client's mental status and psychosocial history. EMHS staff consult a psychiatrist in approximately 75% of the cases, most often by telephone. According to EMHS statistics, during the six-month period

February through July, 1983, between 60-75% of the total clients consulting EMHS each month displayed a "serious primary presenting problem": "suicide ideation" and/or gestures; assaultive, destructive, or bizarre behavior; severe depression; or decompensation.

When the EMHS staff decide that a client should be admitted to an inpatient unit, a placement determination is made. A referral may be made to one of seven hospitals with psychiatric inpatient units in the area, including WSH and University of Massachusetts Medical Center (UMMC). The staff of EMHS first try to place clients in hospitals other than WSH. However, they have experienced resistance from hospitals other than UMMC when referring to Medicaid or free care/bad debt patients; these patients are primarily admitted to WSH and UMMC. A client recommended by EMHS for admission to WSH is referred to the Admissions Office, where the actual admission decision is made. According to the Acting Director of EMHS, the percentage of clients referred by EMHS and accepted by WSH is close to 100%. A client admitted to WSH in this manner would be assigned to the GWU, most often to one of the two admissions wards within the unit.

Approximately 17% of the people admitted to WSH during the six-month period between February and July, 1983 were not referred by EMHS, but by other hospitals, courts, or a direct referral by a GWU psychiatrist. EMHS statistics from February through July, 1983, also show the following:

1. Clients consulted EMHS a total of 995 times, averaging 166 per month;

2. A monthly average of 122 of those consultations, or 73%, were clients who had been seen previously at EMHS, and a monthly average of 44, or 27%, had been seen previously within the same month.

F. CMHC and Central Community Home

FINDING:

BECAUSE OF A LACK OF ALTERNATIVES, CMHC STAFF CONSIDERED CCH TO BE AN ACCEPTABLE RESIDENCE FOR THEIR CLIENTS.

Interviews with CMHC administrators and direct care staff indicated that CMHC staff had more knowledge about the practices and operation of Central Community Home than did GWU staff. CMHC staff knew that CCH housed a significant number of CMHC clients and that the owner of the building also owned other buildings that housed CMHC clients. All knew that CCH provided some supervision and that contact between CCH and CMHC staff was regular. Most CMHC staff viewed CCH within the broader context of the problems of housing for the mentally ill in Worcester, a context summarized in the introduction to a recent CMHC report on housing:

> In a time when the housing shortage has become a major political concern in Massachusetts, it is a crucial issue for the mentally ill. The mentally ill are being forced to compete with other low income and disabled people for a dwindling supply of low cost rental housing. Due to high demand, even the most dilapidated and substandard housing is occupied. For many, poor quality housing is the only housing option, while some are unable to access any housing at all. A growing number of homeless persons must resort to living in shelters or on the street. Many mental health clients are forced to reside in a "Mental Health Ghetto" - the Main South Area of Worcester, where they live in single room occupancy housing.

These problems, combined with the limited number of structured community residences for the mentally ill, left CCH as an accepted, and even preferred residence for CMHC clients. (This is similar to the view taken by hospital staff.) Many CMHC staff said that the minimal supervision and accessibility of the owner to CMHC workers made CCH preferable to "flop-houses" where there is no

supervision, and where caseworkers have a difficult time gaining entry. In addition, many staff complimented the owner of CCH for tolerating some of the most difficult clients, and for "going beyond his responsibility" in providing certain services to clients. (One example of the role CCH plays in the Worcester mental health system is that CCH is listed on the EMHS monthly data gathering sheets, under columns headed "Referred By" and "Referred To".)

FINDING:

CMHC DIRECT CARE STAFF VOICED SERIOUS COMPLAINTS ABOUT CLIENT CARE AND SAFETY AT CCH AND OTHER BOARDING HOUSES. SOME OF THESE PROBLEMS WERE ADDRESSED AFTER THE FIRE.

Most CMHC staff had reservations about CCH that ranged from minor problems to serious complaints. Those CMHC staff with the most direct knowledge of the operation of the home -- ISU workers and CSS and OPD clinicians -- had the most vocal reservations. Those more removed from the situation tended to be less vocal in expressing their concerns about CCH.

The complaints about CCH voiced prior to the fire by OPD and CSS clinicians and ISU workers included the following:

1. Trained staff who had previously been employed at CCH, and who had provided both increased communication with CMHC and better care of residents, were no longer there;

2. There was no night-time supervision of residents;

3. There was no on-site professional monitoring of medication;

4. There had been small fires at the home, and at other buildings belonging to the CCH owner, and there were serious questions about fire safety in these buildings;

5. Many residents were unable to respond promptly and independently to a fire alarm;

6. The house was dirty and rooms were not cleaned by residents or staff;

7. Residents were not provided basic toilet articles, furniture, or linens;

8. There were questions about financial issues, including methods of rent payment, handling of benefits checks, and daily allowances.

Most staff said that problems at CCH had been pointed out to Area Office and CMHC administrators, and others within the mental health system. In response to these concerns, DMH and CMHC administrators said that neither had a contractual relationship with CCH, and therefore had minimal ability to control the conditions there. Most added that CCH was the unavoidable result of a housing shortage and an underfunded community system.

Since the fire, CMHC staff have taken a more active role in addressing what they consider to be the serious problems faced by their clients at CCH, and in similar lodging houses. Some of the actions they have taken include:

1. Helping to update and organize the medicine cabinets in the front office at CCH;

2. Drafting a sample landlord-tenant agreement, and successfully encouraging the owner of CCH to use such a written agreement voluntarily;

3. Establishing, as one of the group programs at The Gathering Tree, an "Apartment Group" in which clients are shown how to improve their living environments, and how to work with landlords to resolve problems;

4. Encouraging better fire safety practices at CCH, such as regular fire drills.

G. Housing Options in the Community

FINDING:

THERE IS NOT ENOUGH HOUSING WITH A RANGE OF LEVELS OF STRUCTURE AND SUPERVISION FOR THE MENTALLY DISABLED IN THE WORCESTER AREA.

Clients in the Worcester aftercare system live in a variety of housing situations, ranging from single-family houses with families, to shelters for the homeless. According to a 1983 CMHC housing report, of the approximately 2,600 clients regularly served by the CMHC, "the largest portion of clients, 42.4%, live with a spouse, son(s), daughter(s) and/or members of their extended family. Only 7.2% live in a group treatment facility, rest home or nursing home. A small percentage, 2.7%, live with other non-related adults. A significant percentage of clients, 19.4%, live alone. The household compositions of the remaining 28% of WACMHC clients is unknown or other than those listed above." A different study of the aftercare system conducted in 1980 provides additional data. Of 974 aftercare clients studied (the total number about whom reliable information was available), 61.5% lived in apartments, 24% in single-family homes, 11.4% in lodging or boarding houses, and 3.4% in community residences.

The 1983 study, entitled "Housing Needs and Resources for the Mentally Ill", points out the instability of housing for this population: "Forty percent

of the WACMHC clients change their residence three times or more per year." The report cites financial uncertainty, poor housing conditions, behavioral problems and hospitalization as the leading causes of this instability.

The focus of the housing problem is the Main South area of Worcester, where approximately 400 CMHC clients live, many in lodging or boarding houses that the report acknowledges are of substandard quality. Central Community Home, not specifically mentioned in the report, is in the Main South area (as are the OPD and CSS clinics, Worcester City Hospital, and other buildings belonging to the CCH owner).

DMH and CMHC recognize the seriousness of the housing problem. Although the Greater Worcester Area currently funds 81 community placements, this supply is far below the need. According to DMH and CMHC staff, the result is two-fold: inappropriate placements in the community, and a higher census on the wards of the GWU. In a report to the Acting Commissioner of DMH in April, 1983 (just before the fire), the Worcester Area Director attempted to address this problem:

> Recognizing that the community residential system is not growing... the area has reprogrammed part of its budget in order to establish two new housing options. The first provides aftercare workers to two community programs that have been successful in moving clients on to independent living. The aftercare workers will increase the rate of flow of clients out of these residential programs while maintaining the program's involvement in supporting the clients. The second option has been to develop a team that looks for housing in the private housing market and then provides support to landlord as well as tenant.

The 1983 housing report cited above is the beginning of the effort described in that memorandum as the second option. In addition, the CMHC has developed an official Policy Statement on Housing, partly in response to the fire at Central Community Home.

That statement, adopted by the CMHC Board of Directors on July 11, 1983, says:

> Recognizing that clients' housing affects mental health, the Center involves itself in issues related to the housing needs of clients. The policy of involvement takes four forms: advocacy for changes within the community, for development of more housing options for the mentally ill, and for assistance from other local organizations; provision of housing for clients by developing and operating residential facilities; consultation services, offered to owners and managers of both public and private, non-profit and for-profit housing facilities; and direct services to clients to help them obtain and maintain housing consistent with their needs. Direct assistance is provided through housing referrals, social rehabilitation efforts, and advocacy with clients' landlords.

IX. CENTRAL COMMUNITY HOME -- FINDINGS AND DISCUSSION

A. Introduction

To assess and understand the operation and practices of Central Community Home, the EOHS team interviewed present and former employees of the home, GWU and CMHC staff who had contact with the home, present and former residents of the home and members of their families, and other Worcester area residents or mental health professionals with a knowledge of the operation of the home.

Central Community Home (CCH) is located at 809 Main Street in the Main South area of Worcester, Massachusetts. A three-story wood frame building approximately 80 years old, CCH also includes a one story community kitchen and dining room. The 13 bedrooms are sparsely furnished; prior to the fire, most rooms needed painting or wallpapering and other improvements. Extensive renovations necessitated by the fire make the interior of the building much more habitable today.

Central Community Home is owned by an individual (hereafter "the owner"), but the home is operated as a closely-held business corporation, The Central Community Home Corporation, and the dining room is operated as a separate business corporation, Community Kitchen, Inc.

The main building is connected to the dining room and kitchen by a short hallway which runs alongside the front office. The hallway contains a narrow window with a small round opening, through which residents receive a daily allowance, cigarettes, and at times, medication. The dining area is a large room with a separate exterior entrance, containing long tables and enough chairs to accomodate 40-50 diners. There is a small galley-like kitchen in the back. From outside, the building looks slightly delapidated. There is a small, unkept front yard, and an uneven dirt parking area.

B. Levels of Care

FINDING:

FROM ITS INCEPTION, CCH HAS PURPORTED TO OFFER CARE AND SUPERVISION TO MENTALLY DISABLED RESIDENTS AND HAS BEEN TACITLY ACCEPTED AS PART OF THE MENTAL HEALTH SYSTEM IN THE WORCESTER AREA.

When CCH first opened in early 1979, the owner held an open house for mental health and other human service providers in the Worcester area. The owner described CCH to them as a lodging house, but one which would provide the level of supervision needed by some former mental patients living in the community. Specifically, the owner said he would: provide shelter and food; tolerate a level of destructive or disruptive behavior higher than that permitted in a typical lodging house; provide monitoring of the residents' condition; and engage in regular communication regarding residents' medication, condition and scheduled appointments with the CMHC. The wife of the owner told the Worcester Telegram shortly after the fire, "It wasn't like we just took their money and fed them. We tried to give them the services they needed." Although most interview subjects generally agreed that CCH did provide some services to residents, the lack of any formal monitoring or record keeping makes it impossible to determine to what extent services were consistently provided.

Shortly after CCH opened, a series of incidents occurred in which medications of residents were lost, stolen, or inappropriately taken or forgotten. As a result, the distribution of medications was centralized, and the medications themselves were stored in locked cabinets in the front office. CMHC direct care staff have, on several occasions, helped organize these medicine cabinets, and the procedures for distribution of medication. Residents receive between one and two week's worth of prescribed medication when they are discharged from WSH.

Subsequent medication is usually prescribed through the CMHC, and ordered for the residents by CCH staff at a local drug store. For nearly all residents, the cost of their regular medication is billed directly by the pharmacy to the Department of Public Welfare and reimbursed with Medicaid funds.

Residents request their medication at regular times or are called from their rooms by CCH staff at the appropriate times. Residents are given their medication in prescribed dosages, in paper cups or in envelopes, and then take it themselves. Missing residents are sought out and told to take their medication. It is a house rule that residents must cooperate and stay on the regular medication program prescribed for them; a range of approaches, from reason to threats of eviction, encourages compliance. Residents' regularly scheduled appointments with their CMHC clinicians are recorded in a daily log book in the CCH office, and CCH staff remind residents of these appointments and encourage them to attend. The staff also serves as a conduit for rescheduling missed or inconvenient appointments. On occasion, CCH staff will use their personal vehicles to provide transportation for residents to their appointments, even though the clinics are within walking distance of CCH.

The meal plan at CCH consists of three meals per day for six days a week, and two meals on Sunday. Meal times correspond to the typical medication schedule, as well as to the scheduling of day programs at The Gathering Tree, a CMHC day treatment center attended by many residents. Meals are served for 30 to 60 minute periods, depending on the meal.

C. Fire Safety and Licensing Status

FINDING:

ALTHOUGH CCH MET ALL APPLICABLE BUILDING AND FIRE SAFETY CODES AT THE TIME OF THE FIRE, IT WAS AN UNSAFE ENVIRONMENT FOR MANY OF THE RESIDENTS LIVING THERE.

Central Community Home is licensed annually as a lodging house by the city of Worcester, and had a current license at the time of the fire. The city of Worcester adopted Article Twelve of the State Building Code, effective July 1, 1975, and pursuant to the Code, the city's Office of Code Enforcement inspects the building annually, and the Worcester Fire Department inspects the building periodically.

There are currently smoke detectors, heat sensors, and portable fire extinguishers on each floor, an audible manual fire pull alarm in two locations on each floor (which is not connected to the local fire station), a sprinkler system throughout the building, and emergency lighting on each floor at the staircases. At the time of the fire, CCH contained all of these provisions but the heat sensors and sprinkler system. The interior of the building includes dropped ceilings of acoustical tile, panelled walls, and wooden staircases, railings, doors, and trim. There are no exit signs, posted floor plans, or evacuation plans. The staircases have no enclosures, leaving three-story vertical airspaces. The back door opens from the inside, but is locked from the outside. CCH met the applicable building and fire safety code requirements at the time of the fire, and with the addition of a sprinkler system, now exceeds them.

According to various CCH staff and residents, there has been a consistent house rule prohibiting smoking in the bedrooms at CCH. Smoking is permitted only in the common areas, such as the T.V. rooms, the porch, or the dining room. This rule, however, has been difficult to monitor or enforce, especially at night, when staff is not present. One nurse formerly employed at CCH stated that she strictly enforced this rule and no fires occurred. However, another nurse stated that many small fires occurred during her employment at CCH usually as a result of careless disposal of smoking materials. She said she regularly extinguished wastebasket and clothing fires that were detected by the smoke

alarms. She believes that her intervention prevented many potentially serious fires from developing further.

Several past and present CCH staff said that fire drills were practiced at the home, although the descriptions of frequency ranged from "monthly" to "occasionally". There was agreement among CCH staff and residents that residents were accustomed to waiting for and responding to direction from some figure of authority or other responsible person during fire drills. Staff said this desensitization to alarms resulted from many drills and false alarms experienced within institutions and various community residences.

Records obtained from the Worcester Fire Department indicate that on March 19, 1983, at 4:30 p.m., one month prior to the fatal fire, there was a small fire on the third floor at CCH. The cause of the fire was the careless disposal of smoking materials by a resident, apparently causing some clothing in the closet of her room to smolder and ignite. The Fire Department responded to an alarm, and, upon arrival, found that the fire had been put out by staff and residents using fire extinguishers.

Site visits and interviews with CMHC staff, the owner of CCH, and past and present residents of CCH comfirmed that the 10-12 other buildings belonging to the owner, in which many mentally disabled people reside, have fewer fire safety provisions, and less staff, than CCH.

D. Central Community Home -- Staff

FINDING:

THE NUMBER AND TRAINING OF THE STAFF AT CCH IS INADEQUATE, IN LIGHT OF THE NEEDS OF ITS RESIDENTS, THE EXPECTATIONS OF GWU AND CMHC STAFF, AND ITS CLAIM TO BE A RESIDENCE ESPECIALLY SUITED TO MENTALLY DISABLED PEOPLE.

The staff at CCH presently consists of the owner, who runs the business, handles the financial arrangements, keeps the books, and staffs the front office on some nights; his sister-in-law, who staffs the front office weekdays, cooks breakfast and dinner, and distributes medications to the residents; one person who staffs the front office weeknights, and functions as a part-time social worker; a part-time LPN, who works at CCH evenings and weekends (in addition to her full-time job on a ward in WSH); additional part-time cooking and cleaning help; and a night watchman, who makes rounds of all of the owner's buildings. The owner's wife also has worked at the home in the recent past, keeping the books and staffing the front office, including during the night.

Of these staff members, only the nurse and the social worker have had any formal education or training in the medical or mental health fields. The social worker, who was formerly an Intensive Services Unit worker at the CMHC, is currently a licensed social worker, and has the equivalent of three years of college education. The nurse has worked on various wards of WSH for 18 years. All of the other staff are high school graduates.

From its inception, CCH has not generally had a staff person present at night, nor was there one on the night of the fire. There has been inconsistent night staffing since the fire.

When CCH first opened in February of 1979, the staff included a full-time licensed practical nurse. She left after six months, and was replaced by another full-time LPN. A third part-time LPN worked evenings during some of this time. These nurses all distributed medication to the residents, and served as contacts for clinicians and social workers at CMHC and WSH. Each of these nurses is or was employed on the inpatient wards at WSH. The two nurses interviewed both stated that they believed that night-time supervision is necessary for these residents, and that they had strongly urged the owner to provide 24-

hour staff on many occasions. There had been no nurses working at CCH from September, 1981, until September, 1983, when the original LPN resumed part-time employment there.

At times, CCH staff also briefly included another licensed social worker and a psychologist, both of whom provided some individual and group therapy to the residents, and regularly communicated with GWU and CMHC direct care staff. Two Two other full-time WSH employees were also employed part-time at CCH in attendant/assistance capacities.

E. Financial Arrangements

FINDING:

THERE WAS POTENTIAL FOR ABUSE OF THE FINANCIAL RELATIONSHIP BETWEEN THE RESIDENTS AND OWNER OF CCH.

Virtually all of the residents of CCH receive public assistance benefits, primarily Supplemental Security Income (SSI) and/or Social Security Disability Insurance (SSDI). Other residents receive General Relief and Food Stamps, and Veteran's and Social Security pensions.

In a few cases, the owner is the "representative payee" for an SSI or SSDI recipient, an official status which gives him complete control over the funds, and makes him responsible for purchasing all of the resident's needs, e.g., clothing. According to local Social Security Administration (SSA) officials, the standard for determining when a recipient of benefits needs a representative payee is "incapacity to handle funds", something less than legal incapacity, but requiring a physician's certificate. The SSA officials said that a recipient's immediate family, or a legal guardian are preferable choices to landlords. Because the owner of CCH is in a category of representative payees from whom the

SSA demands financial accounting, he must submit annual statements of expenditures of benefits received on behalf of those residents. However, no monitoring beyond this document review occurs. The owner of CCH is known to the local SSA office, and regularly submits applications on behalf of residents. He was the representative payee for four of the people registered at CCH at the time of the fire.

Nearly all residents' benefits are mailed monthly to CCH. In most cases, CCH staff will hold the check for the resident to endorse. The owner then goes to the bank, cashes the checks, deposits most of the funds, and returns with the remainder in cash. These procedures for handling resident funds also apply to the benefits received by residents of the other boarding houses belonging to the owner of CCH, many of whom formerly resided at CCH. All the mail for residents of any of these buildings is received at CCH, and distributed from the office. The owner estimates that he handles between 125 and 150 benefit checks in this manner each month. He keeps ledgers of charges for shelter and food, cash advances, cigarettes, and other incidentals. He does not routinely issue rent receipts but has provided receipts to residents and/or their CMHC clinicians when asked to do so.

The owner receives no state or federal funding for operating CCH, and depends entirely on charges paid by residents. A bed at the Central Community Home costs $45 per week or approximately $180 per month. The meal plan costs $155 per month. However, some residents pay for the meal plan by providing only their monthly Food Stamp allotment, or the Authorization to Purchase (ATP), to the owner; the maximum allotment is approximately $75 per month. Residents are advanced $1 per day as spending money, and one pack of generic brand cigarettes per day, for which they are charged $1. These charges total approximately $400 per month; most residents receive a monthly SSI check of approximately $420. The owner deducts room and meal and other charges per month, and the difference

is given to the residents. Most of the 13 bedrooms are occupied by two people, making the total capacity of the building 26-30 residents; the owner estimates the average capacity at 25 residents.

The room and meal charges are deducted prospectively, and any advances or items charged in the prior month (e.g., spending money, cigarettes, medicine not covered by Medicaid, small loans, incidentals) are deducted retrospectively.

According to the owner, if a resident pays in advance for the meal plan for a month and is admitted to WSH or leaves CCH for some other reason during that month, the balance is refunded to the resident. In contrast, according to the owner, if a resident has paid for a bed for one month in advance and is admitted to an inpatient ward at the WSH at any time in the course of the month, the owner keeps the bed open and retains the payment received. He was unable to state clearly a policy for determining the appropriate period for which a bed would be held for a resident under these circumstances.

The EOHS team also found that:

1. The owner will charge a resident less than the standard rates for room and board, if the resident has limited benefits (e.g., General Relief, usually $215/ mo.; plus Food Stamps, usually $75 /mo.).

2. The owner will accept residents and subscribers to the meal plan before they begin receiving benefits, including so-called "homeless" individuals who need an address in order to apply and be eligible for assistance benefits;
3. A past CCH resident known to the owner can always find shelter at CCH;

4. There was no evidence of a single instance of charges in excess of the standard rates, even for "private pay" residents in single rooms.

F. CCH and the Mental Health System

FINDING:

DESPITE WIDELY REPORTED COMPLAINTS ABOUT CCH, THE HOME IS RELIED UPON AS A HOUSING OPTION FOR THAT SEGMENT OF THE MENTALLY DISABLED POPULATION WHO REQUIRE A SIGNIFICANT LEVEL OF FREEDOM AND FLEXIBILITY IN THEIR LIVING ARRANGEMENTS.

From its inception, CCH, and its owner, have attracted criticism from a range of people involved in mental health, social services, and community issues in the Worcester area. There have been a number of articles in Worcester newspapers over the past few years about the homeless, about former mental hospital patients, and about the Main South area in which CCH has been mentioned. An article in the October 8, 1980 issue of the Worcester Magazine described the CCH owner as a businessman who had perceived a need that was created by a variety of economic and social forces, and who had met that need:

> The owner houses former mental patients in apartment buildings on King and Chatham Streets and is reportedly thinking of buying a rest home. But for now, the flagship of his operation is the Central Community Home at 809 Main Street - a dormitory-like rooming house, right in the middle of Main South, that is given over almost entirely to former mental patients.
>
> Its location makes it visible. Its clientele makes it noticeable. Unlike most community-based homes that strive for 'normalization' by keeping a low profile, (CCH) has a big sign in front. Room and board charges leave roomers only $60 a month to live on. (The owner) controls the money of most of his roomers, doling out daily 'allowances'. Limited staff and programs reinforce dependence on (the owner) and limit the possibility of roomer/patients moving on to truly independent living. (The owner) himself has no professional qualifications to run a facility for the mentally ill. And (the owner) is totally unregulated by a government agency.
>
> For all those reasons, (the owner) has become a magnet for criticism about the housing plight of former mental patients.

The differing views about CCH in this article are representative of the differing opinions expressed to the EOHS team in interviews. The following statements were repeatedly made to the EOHS team about CCH and its owner:

1. The owner is highly regarded by families of residents, many of whom refer to CCH as a "rest home" or "halfway house". The owner is highly regarded by past and present residents of CCH.

2. People who have been repeatedly admitted to WSH and who have not been able to be placed in or to live comfortably in more highly structured residential programs in the community are able to live in CCH for extended periods.

3. The owner will tolerate a level of behavior described by mental health professionals as "deviant", "aberrant", "regressed", and beyond the level which is acceptable in some DMH-funded community residential programs.

4. A few years ago, local DMH administrators recognized the owner's success with a certain segment of the clients in the community, and established a DMH-funded community residence, which was partially modeled on CCH.

5. The owner of CCH has apparently developed a sophisticated level of insight and behavior modification techniques through his experience at CCH, and he adapts his procedures to fit the needs, strengths, and weaknesses of particular clients. The owner, for example, will determine the "appropriate placement" among his buildings for a client about to be discharged from WSH.

6. The owner will assist residents in getting admitted to the hospital when they are too ill to get there themselves, often including providing transportation in his personal vehicle at all hours of the day and night.

7. The owner of CCH has a sincere interest in the welfare of the residents.

G. Other Boarding Homes

FINDING:

MANY MENTALLY DISABLED PEOPLE CURRENTLY LIVE IN LODGING HOUSES IN WORCESTER THAT HAVE LESS SUPERVISION AND FEWER SAFETY PROVISIONS THAN CCH.

The owner of CCH also owns 11 other lodging houses in the Main South area of Worcester, which have a total capacity of approximately 170 residents. There are less supervision and fewer fire safety provisions in these buildings than in CCH. According to the owner, approximately 100 of the residents of these other buildings are former mental health patients, but there is no organized monitoring of medication, therapeutic appointments, or the overall condition of the residents. Although there is some range in levels of structure, corresponding to some extent to the needs of the residents, these buildings do not purport to care for mentally ill or otherwise disabled people. Some of the residents of these buildings eat their meals at Central Community Home.

X. LICENSING OF PRIVATE RESIDENTAL FACILITIES: A NATIONAL ISSUE -- FINDINGS AND DISCUSSION

A. Introduction

In assessing the relationship between CCH and DMH as identified in the initial scope of the investigation, it became clear that the fire and safety hazards presented by both the physical condition of CCH and the disabled condition of some of its residents were not unique to CCH nor to Massachusetts lodging and boarding houses. To better understand the problem, the EOHS team surveyed state and national licensing practices and interviewed licensing officials in Massachusetts and other states, including national experts on the issue.

B. Department of Mental Health Licensing Authority

FINDING:

THE DEPARTMENT OF MENTAL HEALTH DOES NOT HAVE A MECHANISM TO REGULATE FACILITIES SUCH AS CCH WHICH ARE NOT OPERATED, LICENSED OR FUNDED BY THE DEPARTMENT.

The Department of Mental Health currently licenses all state-funded community residences for the mentally retarded and has recently begun to license state-funded community residences for the mentally ill. This latter licensing effort is still in an experimental stage in two of the state's districts. DMH does not have enough licensing staff to license all of its funded community mental health residences.

Chapter 19, Section 29 of the Massachusetts General Laws requires DMH to license any facility providing treatment to mentally ill persons. DMH may, but is not required to, license facilities providing care to mentally ill persons. DMH must, however, regulate the operation of such facilities. Since CCH

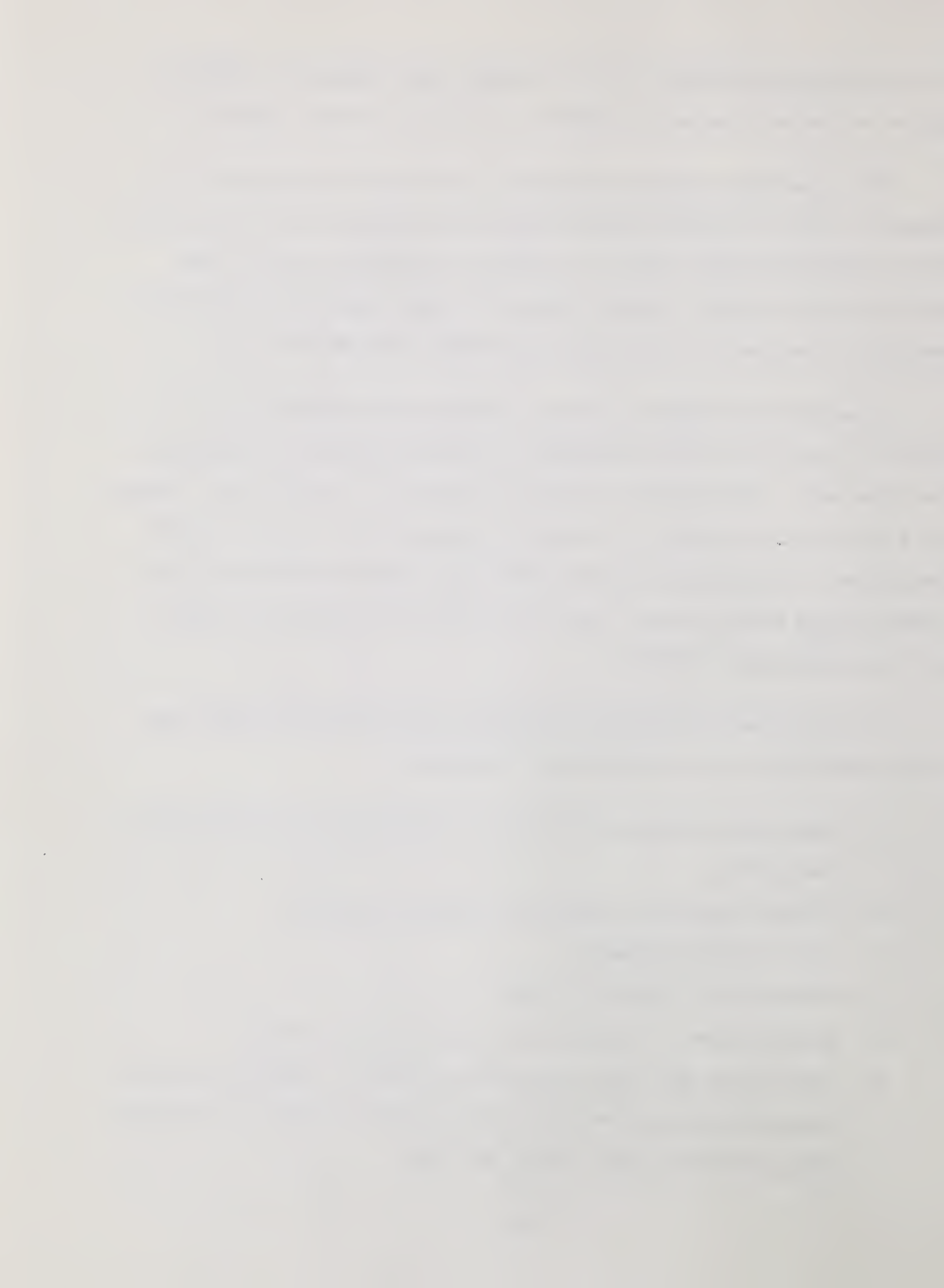
offers care to its residents, who are, in many cases, mentally ill, DMH is authorized but not required by statute to license it, but must regulate it.

DMH's regulations governing residential facilities for the mentally ill, however, limit its licensing authority under this statute to the licensing of a "full residential program" which "is organized exclusively to provide specialized care, treatment, training, education, and/or supervision services for mentally ill persons in a residential environment", 104 CMR 17.13 (2).

Since DMH has not begun to license residences for the mentally ill in District II yet, it is not clear whether CCH would be subject to licensure by the department. The regulations could be interpreted to authorize the licensing of a facility such as CCH as a "residential program" with waivers of certain provisions. In conversations with the EOHS Team, however, DMH licensing and administrative staff said that they did not believe that DMH would license a private lodging house like CCH.

If these community residential regulations were applicable to CCH, they would have imposed the following kinds of standards:

1. Requirements for physical structure and procedures, including regular fire drills;
2. Personnel guidelines, including for medical coverage;
3. Record-keeping procedures;
4. Provisions for inspection by DMH;
5. Emergency medical procedures, including training of staff;
6. Certification and regular retesting of residents' capability of self-preservation, particularly for their ability to evacuate a building in two and one-half minutes in case of fire;



7. Provisions for handling of residents' funds, including standards for performance of representative payees; accountability to the resident, to a guardian or conservator, and to the SSA; and training of residents to manage their own funds.

There is no provision within DMH's regulations for regulating a facility, as opposed to licensing it. Since the Department does not license or fund CCH, there is no mechanism for DMH to regulate it.

C. Current Department of Mental Health Policy for Boarding Homes

FINDING:

THE COMMISSIONER OF MENTAL HEALTH HAS DIRECTED DMH AREA OFFICES TO ENSURE THAT ALL PROGRAMS WITH WHICH THEY CONTRACT OR TO WHICH THEY REFER CLIENTS HAVE CURRENT LICENSES FROM THE APPROPRIATE LICENSING AUTHORITIES.

In a June 24, 1983 policy memo to the Executive Staff, Area Directors, and Facility Heads, the Commissioner of Mental Health wrote:

> It is the responsibility of the Department of Mental Health to ensure that the health, safety, and welfare of individuals under care of the Department are protected. In particular, it is essential that residential settings utilized by the Department for client placement meet applicable building, fire, sanitary, and safety requirements. The Department should neither operate residential programs nor refer individuals to residential settings where the physical environment of such residences endangers the health, safety or welfare of Department clients.
>
> Each area must ensure that residential programs operated or contracted by the Department meet basic fire, health, building and safety codes; and, that fire drills and inspections are up-to-date. In addition, the Department and its contracting agencies are not to refer individuals to private residential settings (i.e boarding homes, private residences, nursing homes, lodging houses, etc.) that are operating without current certificates of occupancy and/or licenses from applicable licensing agencies. For example, boarding and lodging homes are inspected by building inspectors and fire marshalls from the municipalities in which the facilities are located.

The Department must make every effort to ensure that, at a minimum, residential settings housing Department clients meet these basic requirements. It is imperative that residential settings have current certificates of occupance; in situations where the certificate is conditional, there must be an approved plan of correction.

C. Department of Public Health Licensing

FINDING:

THE DEPARTMENT OF PUBLIC HEALTH IS PROHIBITED BY STATUTE FROM LICENSING A FACILITY SUCH AS CENTRAL COMMUNITY HOME, ALTHOUGH IT DOES HAVE THE AUTHORITY TO LICENSE REST HOMES FOR ELDERLY PEOPLE.

The Department of Public Health currently licenses rest homes which have traditionally provided minimal supervision for elderly people who do not need the more intensive support of nursing homes. As the state began to implement policies of deinstitutionalization of its state mental hospitals, rest homes began to receive an increasing number of psychiatric patients. DPH estimates that more than half of the rest homes licensed by the Department report housing residents who transferred from psychiatric facilities and that 30 rest homes house more than 50% psychiatric transfers. (DPH licenses a total of 275 rest homes, serving 7,861 people.) Of the total rest home population surveyed in 1980, 25% were transferred from psychiatric hospitals.

It is interesting to note that, according to DPH licensing staff, current DPH rest home regulations would have required some of the features that most GWU and CMHC staff believe should have been present at CCH, including:

1. a staff person on duty 24 hours a day;
2. standards for the administration and storage of medication;
3. posted evacuation plans.

However, the statutory definition of rest homes found in G.L. Chapter 111, Section 71, specifically pertains to the provision of care "... incident to old age..." Because many mentally disabled young adults live in CCH and other such lodging and boarding houses, current rest home licensing standards are not applicable.

D. The National Problem of Licensing Private Residential Facilities

FINDING:

CCH IS THE TYPE OF FACILITY THAT HAS PROVOKED A NATIONAL CONCERN ABOUT BOARD AND CARE HOMES, WHICH LED TO THE DEVELOPMENT OF THE KEYS AMENDMENT.

Standards of safety and care in private, unregulated failities that house mentally disabled people is not a problem limited to Worcester or to Massachusetts. When state hospitals throughout the country released patients into the community in the 1960s and 1970s, lodging and boarding houses developed as an alternative form of housing for many mentally disabled people. The major source of payment for room and board in these facilities has been federal Supplemental Security Income (SSI) benefits, which is supplemented by some states, including Massachusetts.

As a result of several tragic fires and widespread reports of abuse, both the U.S. Congress and the U.S. Department of Health and Human Services (HHS) began to identify the lack of regulation of these homes as a serious problem. The federal government's ability to regulate these homes, however, was limited because no direct federal funding was involved. In an effort to address this problem, Congress passed the Keys Amendment in 1976, which called for states to locate and establish standards for "group living facilities in which a significant number of SSI recipients resided or were likely to reside, to publish those standards annually, and to certify annually to the Secretary of (Health and Human Services) that each state was in compliance with the above requirements".

These standards were supposed to govern "such matters as admission policies, safety, sanitation, and protection of civil rights." According to a September 1982 Congressional Research Service study entitled, "Board and Care Homes and the Keys Amendment":

> All states have stated their intention to comply with the law, but according to the General Accounting Office (GAO), the states have 'not made a serious effort' to enforce the law. Nor, GAO maintains, has (HHS) shown much willingness to insist that states do so. The DHHS complains that the only sanction available to punish violations of this law is to reduce the SSI checks of residents of homes not in compliance with state regulations, including all those states with no regulations at all. Although this provision was enacted in an effort to deter individuals from moving to or staying in unlicensed or substandard facilities, it is widely held that the provision cannot accomplish its goals.

The Office of the Inspector General of the U.S. Department of Health and Human Services conducted a review of existing regulations governing the Keys Amendment in 1981. That review interpreted the Keys Amendment to apply only to "board and care homes" and found that there is widespread confusion over the distinction between board and care homes and lodging and boarding houses. The review makes the following distinction between these type of homes:

> Boarding homes are residences that simply provide their residents a place to sleep and food while board and care facilities not only offer room and board, but also some form of protective oversight. Thus, the owner (or employee) of a board and care facility might check to see if a resident on medication was taking it according to directions, or help him or her obtain transportation for a doctor's appointment.
>
> Making the distinction between boarding homes and board and care facilities narrows the universe of facilities covered by the Keys Amendment dramatically: our very rough estimates indicate there are 30,000 board and care facilities nationwide, compared with 300,000 boarding homes. As the report points out, it is important that in future public policy discussions, the distinction between the two types of facilities be kept clearly in mind.

E. Compliance with the Keys Amendment

FINDING:

IF MASSACHUSETTS WERE IN FULL COMPLIANCE WITH THE KEYS AMENDMENT, CCH MIGHT HAVE BEEN REGULATED BY A STATE AGENCY AND WOULD HAVE HAD TO MEET ADDITIONAL STANDARDS.

In May 1982, the U.S. Office of the Inspector General performed an audit of Massachusetts' compliance with the Keys Amendment. The audit found that while the Commonwealth had established standards for various types of facilities required to be licensed under the Keys Amendment, the responsible licensing agencies were not performing inspections and issuing licenses in a timely fashion. In addition, it found that procedures had not been established to insure that all facilities under the Amendment were identified. The Inspector General found that there were about 1,950 facilities in Massachusetts which should at least be examined to determine whether they provide the type of "protective oversight" covered by the Keys Amendment.

In 1982, the Executive Office of Human Services assumed responsibility from the Department of Social Services for the enforcement of the Keys Amendment. Since then, the Department of Public Health and Mental Health have increased inspections and licensing. However, EOHS has still not established procedures to insure that all facilities subject to regulation under the Keys Amendment have been identified. Facilities such as CCH, therefore, which provide a degree of "protective oversight" to a significant number of SSI recipients, remain subject only to local building codes. These codes do not address admission policies and the protection of civil rights. In addition, the safety and sanitation standards of the codes are general and do not take into consideration the needs of a significant number of the residents of a facility such as CCH, as required by the Keys Amendment.

Mental Health professionals interviewed by the EOHS team expressed concern that state regulation of facilities such as CCH would cause some owners either to stop providing additional care and revert to operating traditional lodging and boarding houses, or to close the homes altogether. Since facilities like CCH provide housing and a certain level of care to individuals who do not choose to live in state-funded residences or for whom state-funded residences are not available, these results should be avoided. In addition, it is not clear that the Commonwealth has the authority under state law to regulate a facility such as CCH, nor is it clear that CCH offers sufficient "protective oversight" to bring it under the Keys Amendment. Until EOHS completes the process of identifying all Keys Amendment facilities, no conclusion can be reached as to whether CCH should have been regulated under the Keys Amendment.

FINDING:

IF CCH WERE LICENSED AS A kEYS AMENDMENT FACILITY, THE COMMONWEALTH COULD AUTHORIZE THE PAYMENT OF HIGHER BENEFIT LEVELS TO RESIDENTS ELIGIBLE FOR SOCIAL SECURITY. THIS ADDITIONAL REVENUE COULD OFFSET THE COST OF ADDITIONAL REQUIREMENTS IMPOSED THROUGH REGULATION.

There may, however, be financial incentives for a facility like CCH to obtain licensure by the state as a "Keys Amendment facility". Federal law authorizes the Commonwealth to pay Supplemental Social Security benefits to eligible individuals living in Keys Amendment facilities. (20 U.S.C. 416.2030)

It is this law, for example, that authorizes higher benefit payments to residents of rest homes and congregate housing. The additional services provided by CCH to its residents are not unlike the care provided in rest homes or congregate housing. The Commonwealth has the ability, therefore, to authorize the higher supplemental payments to the residents of homes such as CCH, if they were considered Keys Amendment facilities. The financial incentive, to both the residents and the owners of facilities such as CCH, might encourage the operation of board and care homes, as distinguished from lodging and boarding houses. It might also prevent either the closing of these housing alternatives or the conversion of these houses -- which now provide varying levels of care -- to traditional lodging houses that only provide a place to sleep.

APPENDIX A

APPENDIX A

WORCESTER FIRE INVESTIGATION PLAN

I. Introduction

II. Preliminary Study

III. Scope of Investigation

IV. Method and Procedures of Investigation

V. Executive Office of Human Services Team

ATTACHMENT I - Resume of Dr. Arthur Papas

ATTACHMENT II - Preliminary Statement to Interview Subjects

ATTACHMENT III - Standard List of Questions

I. INTRODUCTION

On April 19, 1983 at approximately 2 a.m., a fire broke out at Central Community Home, a privately owned and operated rooming house at 809 Main Street in Worcester, Mass. Twenty-three people were registered at the house at the time of the fire. Of that group, 21 had been patients at Worcester State Hospital, a Department of Mental Health facility. Seven people died in the fire, five of whom were former patients at Worcester State Hospital. On April 21, Human Services Secretary Manuel Carballo announced that his General Counsel, Mary Kay Leonard, would lead an investigation into the circumstances and issues surrounding the fire.

II. PRELIMINARY STUDY

Before developing a detailed investigation plan, the Executive Office of Human Services team conducted a preliminary study to determine the nature, scope and procedures of the investigation. Meetings and discussions were held with: the state police officer from the Worcester County District Attorney's Office investigating the fire; members of the Special Senate Committee on Deinstitutionalization that was created on April 20 following the fire; and the Department of Mental Health Central, District and Area staff.

As a result of these meetings, the Executive Office of Human Services team concluded that:

A. The investigation should have a broad focus and include an examination of: the discharge decisions at Worcester State Hospital for those former patients who were residents of Central Community Home on April 19; the aftercare provided in the community for these and other residents; the practices of Central Community Home; and the relationship between Central Community Home and the Department of Mental Health.

B. The investigation should include, as an expert consultant, an independent psychiatrist who would evaluate the records of discharge decisions at Worcester State Hospital and aftercare provided in the community for each

each resident of Central Community Home. The psychiatrist should be familiar with institutional psychiatric care, aftercare in community settings, and the structure of the Department of Mental Health, but should be independent of the Department of Mental Health.

C. The investigation should be preceded by a written investigation plan and should follow the principles and procedures of that plan.

D. The Department of Mental Health should be given an opportunity to review and comment upon a draft report.

E. The investigation should result in a final report to the Secretary, incorporating any comments from the Department of Mental Health.

The Executive Office of Human Services team then conducted an extensive search for a psychiatrist. Twenty-five psychiatrists and mental health professionals were consulted and four were interviewed. Dr. Arthur Papas, a staff psychiatrist at Emerson Hospital in Concord, Mass. was chosen for the investigation. Dr. Papas is an instructor in psychiatry at Harvard Medical School and has been an assistant professor of psychiatry at Tufts Medical School. From 1973 to 1978, he served as director of psychiatry at Metropolitan State Hospital, and is familiar with the structure and practices of the Department of Mental Health. (See resume of Arthur N. Papas, M.D., Attachment I)

The Executive Office of Human Services team then prepared an Investigation Plan, and the introductory statements and standard list of questions contained in Attachment II.

III. SCOPE OF INVESTIGATION

The investigation will examine the circumstances and issues surrounding the fire on April 19, at Central Community Home at 809 Main Street, in Worcester, Mass.

The investigation will:

A. Examine the records of discharge decisions, treatment plans, and other records of all of the residents of Central Community Home at the time of the fire who had been patients at Worcester State Hospital or clients of the Worcester Area Community Mental Health Center.

B. Examine the extent to which the Department of Mental Health and any other governmental agency monitored and provided services to the residents of Central Community Home.

C. Examine the practices of Central Community Home.

D. Examine the relationship between Central Community Home and the Department of Mental Health.

IV. METHOD AND PROCEDURES

A. Hospital and Community Mental Health Center Records.

The Executive Office of Human Services team will secure access to all medical and other records of the Department of Mental Health relating to residents of Central Community Home. These records, which will be inspected by Dr. Papas and other members of the Executive Office of Human Services team, will be obtained with the permission of the Commissioner of Mental Health, under the authority granted him in G.L. c. 123 S. 36. These records will be kept strictly confidential.

B. Other Records and Statements

The Executive Office of Human Services team will examine all other records, statements, written policies and procedures, and any other documents relevant to the investigation.

C. Interviews

The Executive Office of Human Services team will conduct interviews with:

1. Department of Mental Health Central, Regional, and Area Staff.

2. Administrative and clinical staff of the Greater Worcester Unit of Worcester State Hospital.

3. Administrative and clinical staff of the Worcester Area Community Mental Health Center.

4. The owner and staff of Central Community Home.

5. Residents of Central Community Home and other clients of the Worcester mental health system.

6. Other people involved in providing mental health and human services in Worcester, concerned citizens, and anyone offering information or asserting a complaint about the Central Community Home, or about the Worcester Area mental health system.

7. State and National Authorities in fire safety, community mental health, and licensing.

8. Representatives form the Worcester Fire Department, the Worcester County District Attorney's Office, the National Fire Proctection Association, and the Worcester Code Enforcement Agency.

9. Representatives of the Trustees of Worcester State Hospital and the Worcester Area Mental Health Board.

Interviews will conform to the following guidelines, as set forth in the Preliminary Statement to be made to subjects at the beginning of each interview (see Attachment II):

1. Interview subjects will be advised of the nature and purpose of the investigation;

2. Interviews will be recorded, whenever possible, to ensure accuracy of the record;

3. Interview subjects may record the interview themselves, should they wish to do so;

4. Every effort will be made to keep interviews confidential, consistent with applicable law and regulations;

5. Interview subjects will be advised of their rights under the investigation; and

6. A list of standard questions will be asked of interview subjects, when appropriate, to help assure consistency and objectivity in the investigation. Additional questions may also be asked.

V. EXECUTIVE OFFICE OF HUMAN SERVICES TEAM

The Executive Office of Human Services team is composed of the following members:

A. Director of Investigation: Mary Kay Leonard, Esq.

Mary Kay Leonard is the General Counsel for the Executive Office of Human Services. She has experience as an attorney and experience with the administration of human services, particularly in mental health areas.

B. Investigator: Arthur Papas, M.D.

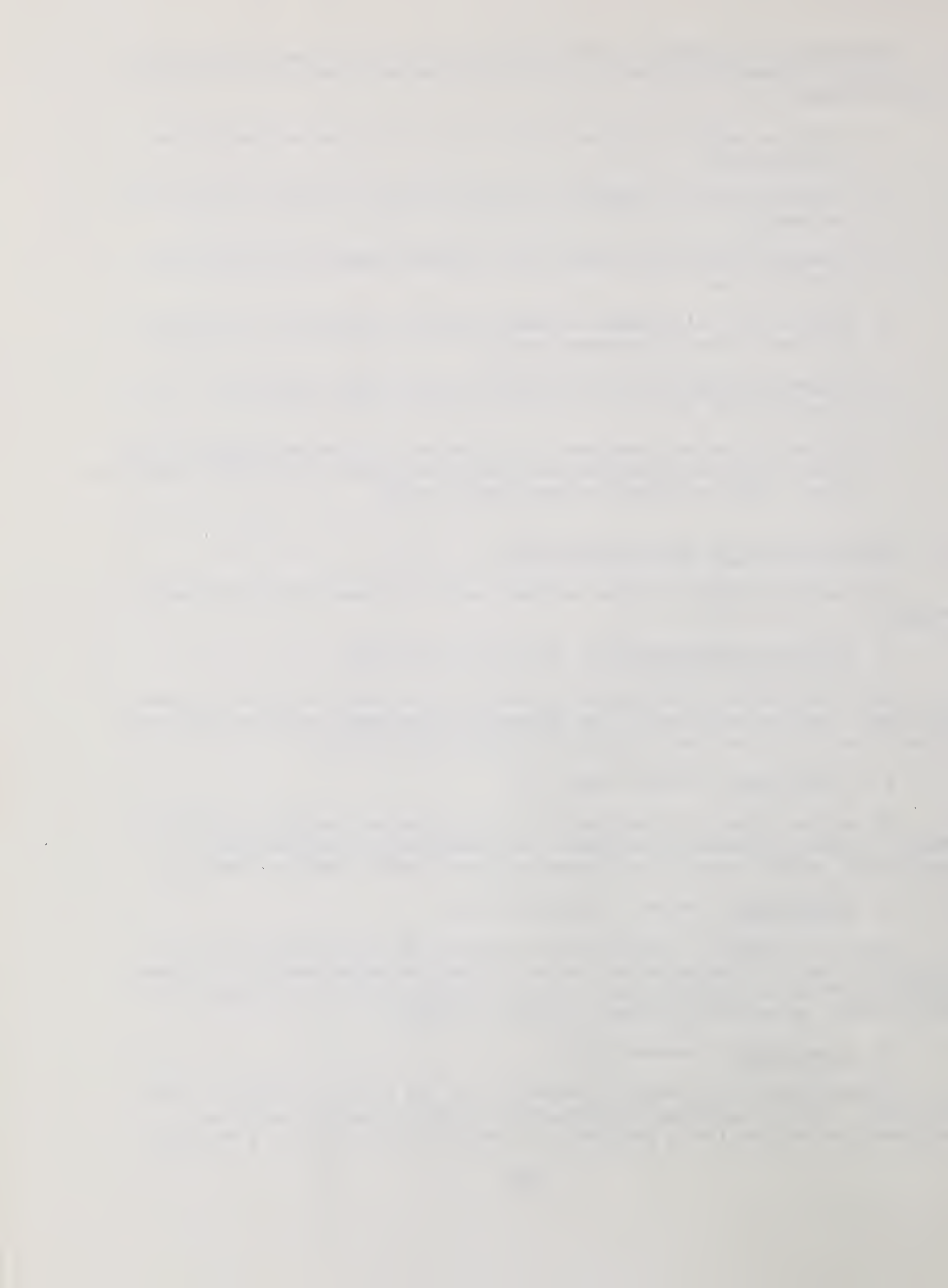
Dr. Arthur Papas is a staff psychiatrist at Emerson Hospital in Concord, Mass. He has an extensive knowledge of and experience in institutional psychiatry, medical records, and community mental health (See Attachment I).

C. Investigator: Bruce F. Blaisdell, Esq.

Bruce F. Blaisdell is Deputy General Counsel for the Executive Office of Human Services. He has experience as an attorney and experience with the administration of human services, particularly in the areas of the purchase of service system, and auditing of human service providers.

D. Investigator: Andrew Dreyfus

Andrew Dreyfus is a Project Coordinator for the Executive Office of Human Services. He has experience with Department of Mental Health issues and programs and was previously employed as a reporter and editor for a newspaper.



CURRICULUM VITAE

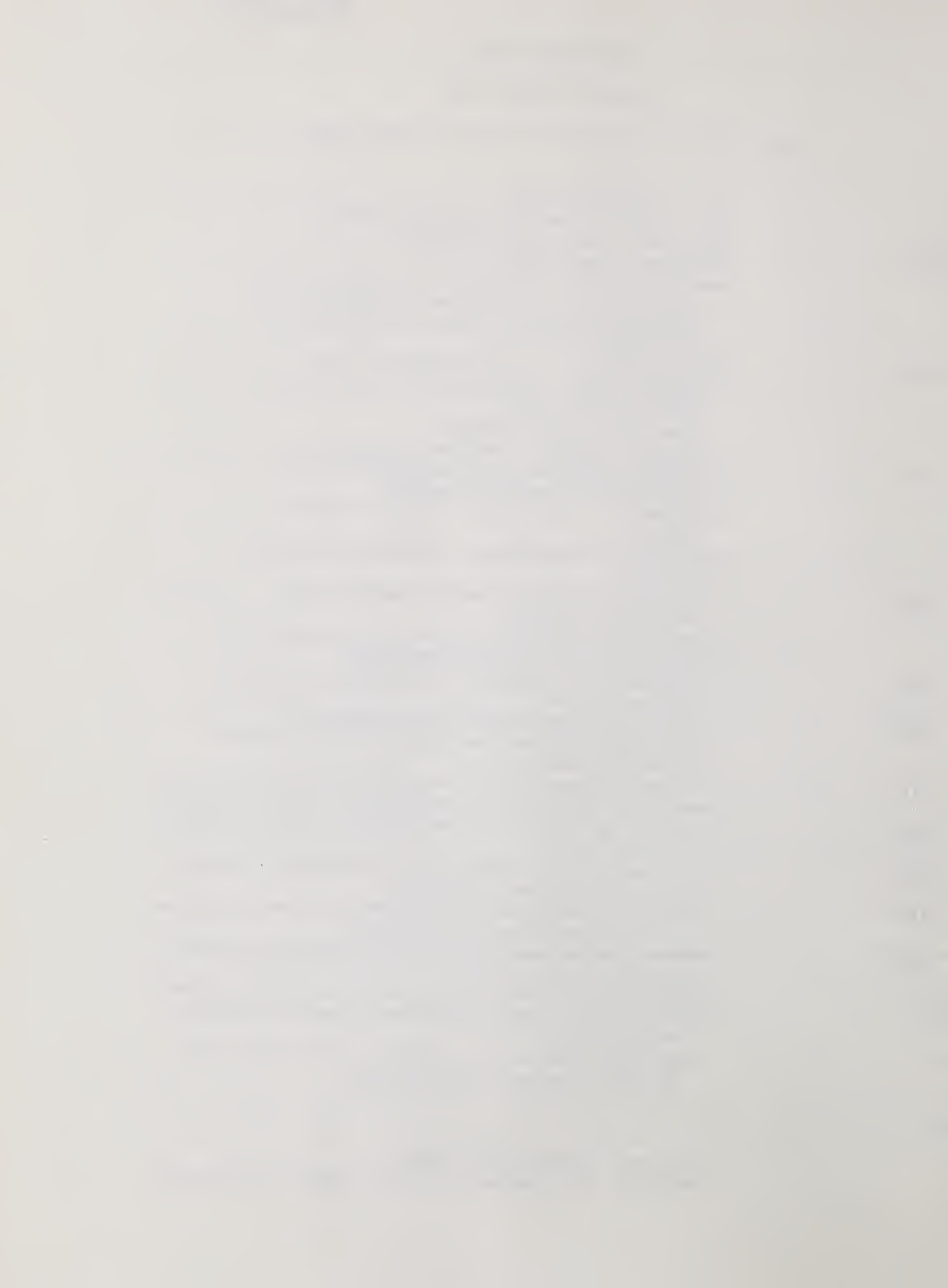
Arthur N. Papas, M.D.

Born - January 11, 1938 - Boston, Massachusetts

1959	A.B., Harvard College
1963	M.D., Tufts University School of Medicine
1963 - 1964	Internship, Boston City Hospital
1964 - 1967	Resident in Psychiatry
	Teaching Fellow in Psychiatry, Langley Porter Neuropsychiatric Institute, University of California Medical Center, San Francisco, California
1967 - 1969	Medical Officer, United States Air Force Medical Corps, Wright-Patterson Air Force Base, Dayton, Ohio
	Director, Alcohol Program
	Chief, Psychiatric Service Section
1969 - 1970	Associate Director, Out-Patient Psychiatry, Massachusetts General Hospital
1969 -	Instructor in Psychiatry, Harvard Medical School
	Assistant in Psychiatry, Massachusetts General Hospital
1970 - 1973	President, Community Association Serving Alcoholics, Boston
	Member - ABCD-OEO Task Force on Alcoholism for Boston's Low Income Neighborhoods
1970 - 1973	Consultant in Alcoholism (Psychiatry), Chelsea Soldier's Home
1970-- 1973	Private Practice (Mass General Hospital)
1970 -	Consultant in Alcoholism (Psychiatry), Bedford Veteran's Hospital
1972 - 1974	Chairman, Boston Alcohol Detoxification Project, Inc.
1973 -	Associate Attending, McLean Hospital, Belmont, Mass.
1973 - 1978	Director of Psychiatry, Metropolitan State Hospital, Waltham, Mass.
1973 - 1979	Assistant Clinical Professor of Psychiatry, Tufts University School of Medicine
1974 - 1976	Chairman, Massachusetts Psychiatric Society Committee on Psychiatric Residency Training
1974 - 1976	Member, Massachusetts Psychiatric Society Committee of Legislative Action
1978 -	Staff Psychiatrist, Emerson Hospital, Concord, Mass.
1978 -	Member, Massachusetts Psychiatric Society Committee on Fellowship
1978 -	Psychiatric Consultant, Hellenic Nursing Home For The Aged, Canton, Massachusetts

Honors

1969	Air Force Commendation Medal
1978 -	Examiner, American Board of Psychiatry and Neurology



Professional Societies

Diplomate, American Board of Psychiatry and Neurology, January, 1972
American Psychiatric Association (Fellow)
Massachusetts Medical Society
Massachusetts Psychiatric Society

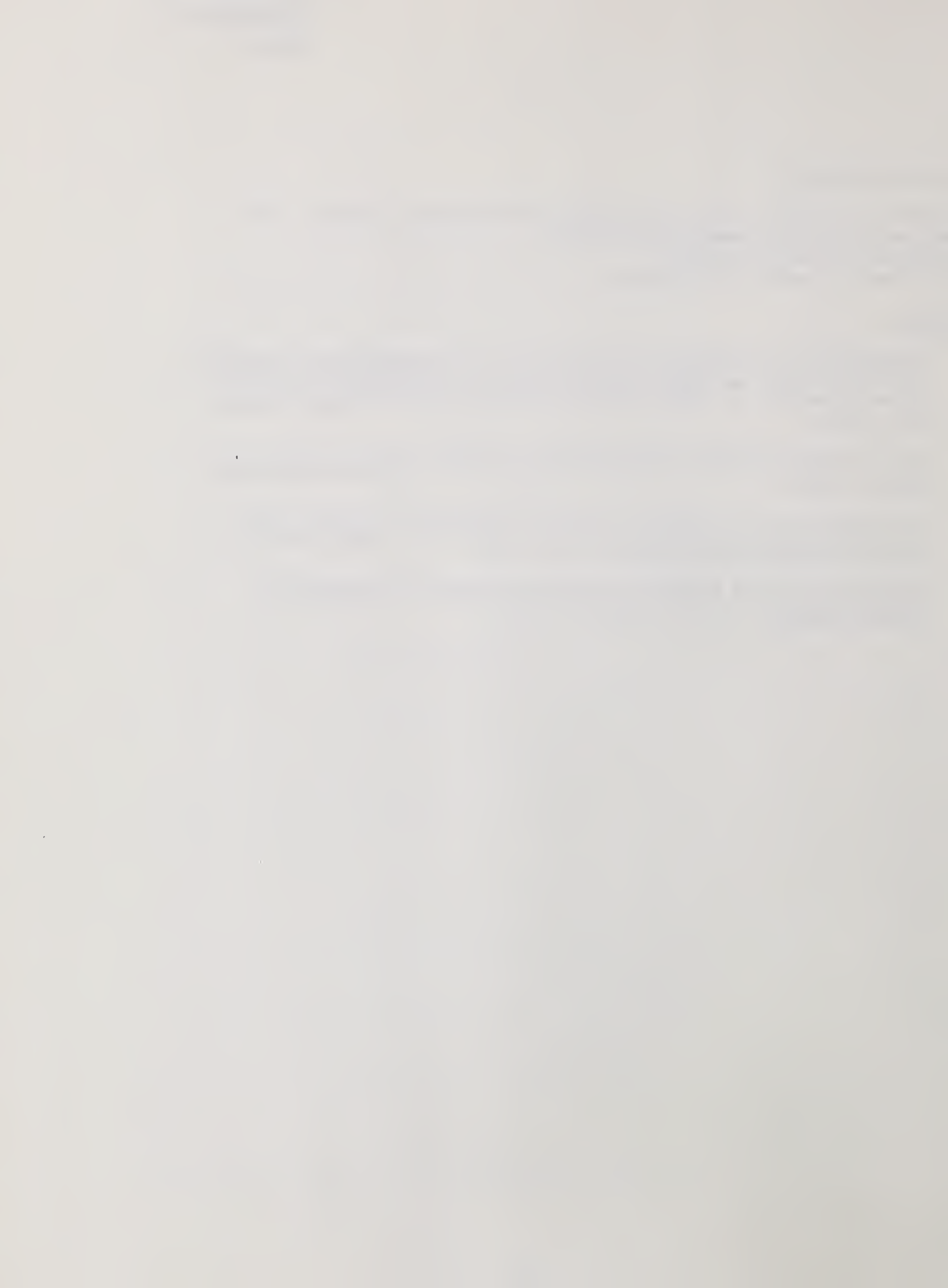
Publications

1. "Approaches to Alcoholism in the Military", The Impact of Alcoholism, Hearings before the Special Subcommittee on Alcoholism and Narcotics of the Committee on Labor and Public Welfare, United States Senate, July, 1969.

2. "An Air Force Alcoholic Rehabilitation Program", Military Medicine, March 1, 1971.

3. "A Program for the Hospital's Alcoholic Employee", Journal of the American Hospital Association, March, 1973.

4. "Questions Doctors Frequently Ask About Alcoholism", Resident & Staff Physician, May 1976, pages 145-149.



ATTACHMENT II

PRELIMINARY STATEMENT TO INTERVIEW SUBJECTS

A. This investigation was ordered by Manuel Carballo, Secretary of Human Services to examine the circumstances and issues surrounding the fire which occurred at Central Community Home, 809 Main Street, Worcester, Mass., on April 19, 1983, in which seven people died. Many of the residents of the house, including five of the deceased, were former patients at Worcester State Hospital. The investigation will focus on the discharge decisions at Worcester State Hospital, the aftercare in the community, the practices of Central Community Home, and the relationship between the Central Community Home and the Department of Mental Health.

This investigation is being conducted by the Executive Office of Human Services, not the Department of Mental Health, and is not subject to the regulations promulgated by the Department of Mental Health regarding investigations.

This is a confidential investigation, which will result in a report to the Secretary of Human Services. The Department of Mental Health will be given an opportunity to comment upon a draft of the report. The Secretary will make appropriate determinations at that time, regarding actions to be taken or disclosure of all or any portion of the report.

B. In the interest of preserving an accurate record of this interview, we intend to tape record all proceedings, unless you wish to go off the record.

C. We are willing to go off the record, but only to obtain information which we cannot obtain on the record, and which will assist us in properly conducting this investigation. If we go off the record, that portion of your statement will not be recorded, mechanically or in writing, and will not appear in any report or other such document, and will not otherwise be disclosed by us.

D. You have the right to record the interview yourself, or to take notes, should you wish to do so.

E. We will make every effort, consistent with applicable laws and regulations, to keep anything said in this interview confidential. However, it is possible that we may legally be compelled, at some time in the future, to disclose at least the substance of any statement you make, or even the statement itself.

F. You have the right to consult with an attorney, or any other appropriate advisor or representative, before you speak with us, or even during the interview. If you are in any way employed by or through the Commonwealth, please be advised that we are required to report any statement you make, or an refusal to answer one or more questions, which indicates improper conduct by you or another person. Such information may be used administratively in disciplinary proceedings, which may lead to some sanction, up to and including termination of employment. Do you understand your rights, as we have descibed them to you? Do you have any questions about your rights? Do you have any questions about how the interview, or the investigation, is to be conducted?

ATTACHMENT III

LIST OF STANDARD QUESTIONS

A. Discharge decisions at Worcester State Hospital

1. What is the ward structure and staffing pattern of the Greater Worcester Unit (GWU) at Worcester State Hospital (WSH)?

2. How are discharge decisions made at WSH?

3. Who has final responsiblity for the discharge decision?

4. How does WSH work with the Commmunity Mental Health Center (CMHC) in discharge decisions?

5. Do all discharged patients have a discharge summary and treatment plan?

6. How are these plans developed and how are they monitored in the community?

7. Does the hospital maintain contact with the aftercare team?

8. What role does the hospital play when a discharged patient experiences an emergency or crisis?

9. How are patients readmitted to the hospital? What percentage of patients have been previously admitted?

10. Are patients discharged directly from WSH to Central Community Home (CCH)?

11. If so, how are arrangements made?

12. Are other options studied for placement for those patients at Central Community Home?

13. Do you have any other information about discharge decisions or other practices at the hospital that would be relevant to this investigation?

B. Treatment and Aftercare in the Community

1. What is the structure of the community mental health system in Worcester?

2. Who takes responsiblity for former mental hospital patients that are living in the community?

3. How does the Worcester Area Community Mental Health Center (CMHC) operate and what is its relationship to WSH?

4. How are aftercare and treatment plans developed for discharged patients?

5. Who monitors these plans?

6. How often are clients seen by aftercare workers?

7. What is the relationship between the aftercare team and the staff at Central Community Home?

8. How does the aftercare team monitor medication at Central Community Home?

9. How does the aftercare team monitor therapeutic and other appointments of residents of Central Community Home?

10. How does the aftercare team deal with emergencies and crises?

11. What is the relationship between the aftercare team and the Worcester State Hospital?

12. How does the aftercare team coordinate or communicate with other human service agencies?

13. How does the aftercare team communicate or coordinate with other providers of social, rehabilitative, and health services in the Worcester community?

14. Do you have any other information about aftercare treatment in the community that would be relevant to this investigation?

C. The Practices of Central Community Home

1. What is your professional relationship with Central Community Home?

2. Have you had any direct contact with the owner or staff of Central Community Home?

3. Do you have any knowledge of the financial operation of Central Community Home, particularly in regard to the method of payment for rooms and meals or the method for handling the money of residents?

4. Do you know the extent to which staff at Central Community Home seek mental health and social services for residents?

5. Do you know how regularly the aftercare team has contact with residents of Central Community Home?

6. Do you know how regularly the aftercare team has contact with the staff of Central Community Home?

7. Do you know how medication is dispensed at Central Community Home?

8. Do you know any facts about the fire on April 19 at Central Community Home which have not been publicly reported?

9. Do you have any information about the treatment of residents at Central Community Home that has not been publicly reported?

10. Do you have any additional information about Central Community Home that would be relevant to this investigation?

D. Relationship between Central Community Home and the Department of Mental Health

1. Are patients discharged directly from Worcester State Hospital to Central Community Home?

2. If so, how are arrangements made?

3. Are residents referred to Central Community Home from other institutions in the Worcester area (e.g., Worcester City Hospital)?

4. What is the relationship between the Worcester Community Mental Health Center and its aftercare teams, and Central Community Home and its staff?

5. How do aftercare teams monitor medication at Central Community Home?

6. How do aftercare teams monitor therapeutic and other appointments of residents of Central Community Home?

7. Do you know the extent to which staff at Central Community Home seek mental health and social services for residents?

8. Do you know how regularly the aftercare teams have contact with residents of Central Community Home?

9. Do you know how regularly the aftercare teams have contact with staff of Central Community Home?

APPENDIX B

GREATER WORCESTER AREA OFFICE

John Ford
Area Director

Leonard Ames
Associate Area Director

Don Piktialis
Contract Officer

WORCESTER STATE HOSPITAL

Dr. Kenneth Lorenz
Clinical Director, Greater Worcester Unit

Joan Fiorentino
Unit Director, Greater Worcester Unit

Carol Cannon
Assistant Unit Director, Greater Worcester Unit

Dr. Andreas Lattice
Psychiatrist, Greater Worcester Unit

Michael Rubin
Principle Psychologist, Greater Worcester Unit

Rose Berte
Social Worker, Greater Worcester Unit

Joanne Young
Social Worker, Greater Worcester Unit

William Quiles
Mental Health Assistant, Greater Worcester Unit

Dr. Bhaskar Patil
Clinical Director, Regional Services Unit

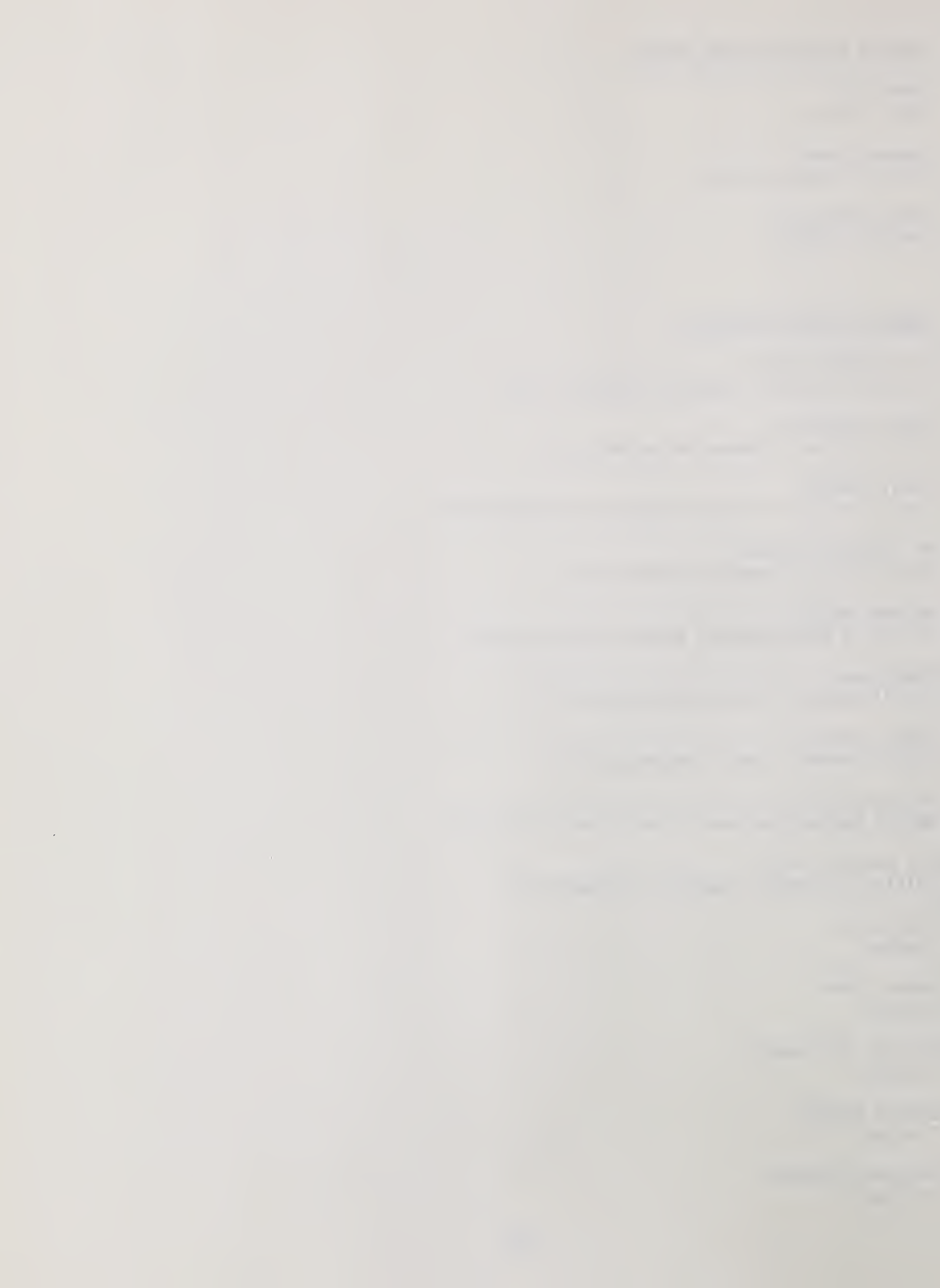
Gail Watson
Trustee

Arthur Moore
Trustee

Marilyn Helfenbein
Trustee

George Haddad
Trustee

Margaret Donovan
Trustee



WORCESTER AREA COMMUNITY MENTAL HEALTH CENTER

David Higgins
Executive Director

Dr. Jerry Schlater
Director, Clinical Services

Dr. Kenneth Lorenz
Director, Medical Services

Elaine Fallon
Director, Community Support Services

Irene Kramer
Director, Outpatient Department

Anne Bateman Schartner
Acting Director, Emergency Mental Health Services

Ellen Pelaquin
Assistant Coordinator, Community Support Services

Nancy Day
Assistant Coordinator, The Gathering Tree

Michael Belavitch
Coordinator, Intensive Services Unit

Julie Tessler
Residential Resources Developer

Randall Rice
Intake Coordinator

Carol Pingatori
Clinician, Community Support Services

Patricia Williamson
Clinician, Outpatient Department

Loraine Mann
Clinician, Outpatient Department

Judith E. Alexander-Daigle
Clinician, Emergency Mental Health Services

Ann Wetton
Case Worker, Intensive Services Unit

Barbara Lee
Former Assistant Nurse Supervisor, Outpatient Department

CENTRAL COMMUNITY HOME

Fred Koza
Owner

Joyce Tolson
Social Worker

Nancy Tarallo
Office Staff

Janice Quiles
Former Nurse

Harvey Kraslin
Former Social Worker

Estelle Bernier
Former Nurse

PRESENT AND FORMER RESIDENTS OF CENTRAL COMMUNITY HOME

Resident #1
Former patient, Worcester State Hospital; client, Outpatient Department.
Resident at Central Community Home at time of interview and at time of fire.

Resident #2
Former patient, Worcester State Hospital; client, Outpatient Department.
Not physically present night of the fire.

Resident #3
Former patient, Worcester State Hospital; client, Outpatient Department.
Resident at Central Community Home at time of interview, readmitted to Worcester State Hospital day of fire.

Resident #4
Former patient, Worcester State Hospital; client, Community Support Services.
Former resident at Central Community Home, current resident at 8 King Street, a boarding house also belonging to Central Community Home owner.

Resident #5
Former patient, Worcester State Hospital; client, Community Support Services.
Former resident at Central Community Home, current resident at 28 King Street, a boarding house also belonging to Central Community Home owner.

Resident #6
Former patient, Worcester State Hospital; client, Community Support Services.
Former resident at Central Community Home, current resident at 92 Chatham Street, a boarding house also belonging to Central Community Home owner.

Resident #7
Current patient, Worcester State Hospital; client, Community Support Services.
Resident at Central Community Home at time of the fire.

Resident #8
Current patient, Worcester State Hospital; client, Outpatient Department. Resident at Central Community Home at the time of the fire.

Resident #9
Current patient, Worcester State Hospital; client, Outpatient Department. Resident of Central Community Home until readmitted to Worcester State Hospital two days before fire.

FAMILIES OF RESIDENTS OF CENTRAL COMMUNITY HOME

Sister and brother-in-law, also acting as representative payee, of former patient of Worcester State Hospital, resident of Central Community Home presently and at time of fire.

Sister of former patient of Worcester State Hospital, resident of Central Community Home presently and at time of fire.

Mother of former patient of Worcester State Hospital, resident of Central Community Home presently and at time of fire.

WORCESTER CITY OFFICALS

Norton Remmer
Commissioner, Department of Code Enforcement

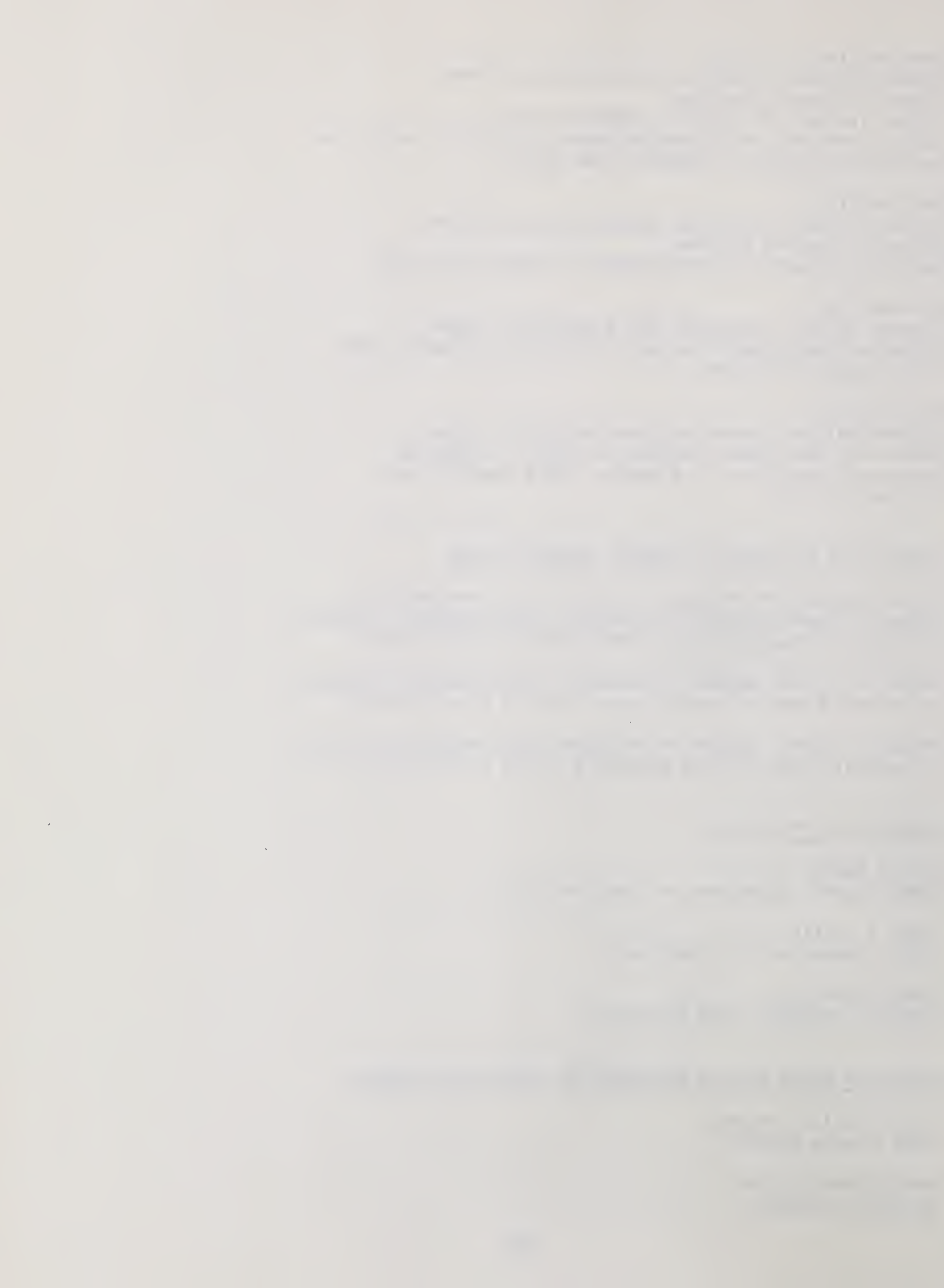
James F. Nally
Chief, Worcester Fire Department

Joseph Hennigan
Captain, Worcester Fire Department

WORCESTER HUMAN SERVICE PROVIDERS AND CONCERNED CITIZENS

Sister Elaine Lamoureux
Abby's House Shelter

Deacon John W. Egan
Jeremiah's Hospice



Edward McCan
Public Inebriate Program

Heather McDonald
Ozanam House

Stephen Green
Concerned Citizen

Douglas Shannon
Westside Pharmacy

Gerry D'Agistino
Reporter
Worcester Magazine

Julie Ferguson
Public Inebriate Program

Jonathan Prouty
Worcester Committee on the Homeless

Sister Mary Christopher
St. Paul's Outreach

Carolyn Packard
Former Counselor
Housing Information Center

Paul Groesbeck
Former Director
Housing Information Center

James Wallace
Former President
Worcester Area Mental Health Board

DEPARTMENT OF MENTAL HEALTH CENTRAL OFFICE AND MISCELLANEOUS AREA OFFICES

Donna Mauch
Assistant Commissioner for Mental Health

Michael Weeks
Chief of Licensing

Richard Ames
General Counsel

Judith Gilbert
Assistant General Counsel

James Duffy
Area Director, Springfield

Audrey Young
Area Director, Lynn

Dr. Miles Shore
Area Director, Mass. Mental Health Center

Rae O'Leary
Associate Area Director, Brockton

Pat Buckley
Outreach Specialist
Brockton Multi-Service Center

Thomas Libbos
Counsel

OTHER EXECUTIVE OFFICE OF HUMAN SERVICES AGENCIES

Jules Godes
Director of Procedures
Department of Public Welfare

Robert Selling
Assistant Director of Procedure
Department of Public Welfare

Herman Gaines
General Counsel
Veterans Services

David Roush
Assistant Director for Survey Operations
Division of Health Care Quality
Department of Public Health

Marilyn Gallivan
Asssistant Director for Survey Operations
Division of Health Care Quality
Department of Public Health

Kathleen Connoly
Assistant Director of Policy Analysis
Division of Health Care Quality
Department of Public Health

John Hess
Policy Analyst
Division of Health Care Quality
Department of Public Health

OTHER - COMMONWEALTH OF MASSACHUSETTS

Roberta Brown
Chief, Torts Division
Attorney General's Office

Det. Lieut Ralph DeFuria
State Police

John Conte
District Attorney
Worcester County

Joseph Kelleher
Inspector
Department of Public Safety

STATE AND NATIONAL EXPERTS IN MENTAL HEALTH, FIRE SAFETY, LICENSING, AND BENEFITS

Ken Carhill
Service Area Chief
California Department of Mental Health

Hetti Stephenson
Program Analyst
Community Care Licensing
California Department of Social Services

Paul Daraghy
Associate Director
Health Facilities Division
Colorado Department of Health

Jonas Moreheart
Fire Protection Engineer
U.S. Department of Health and Human Services

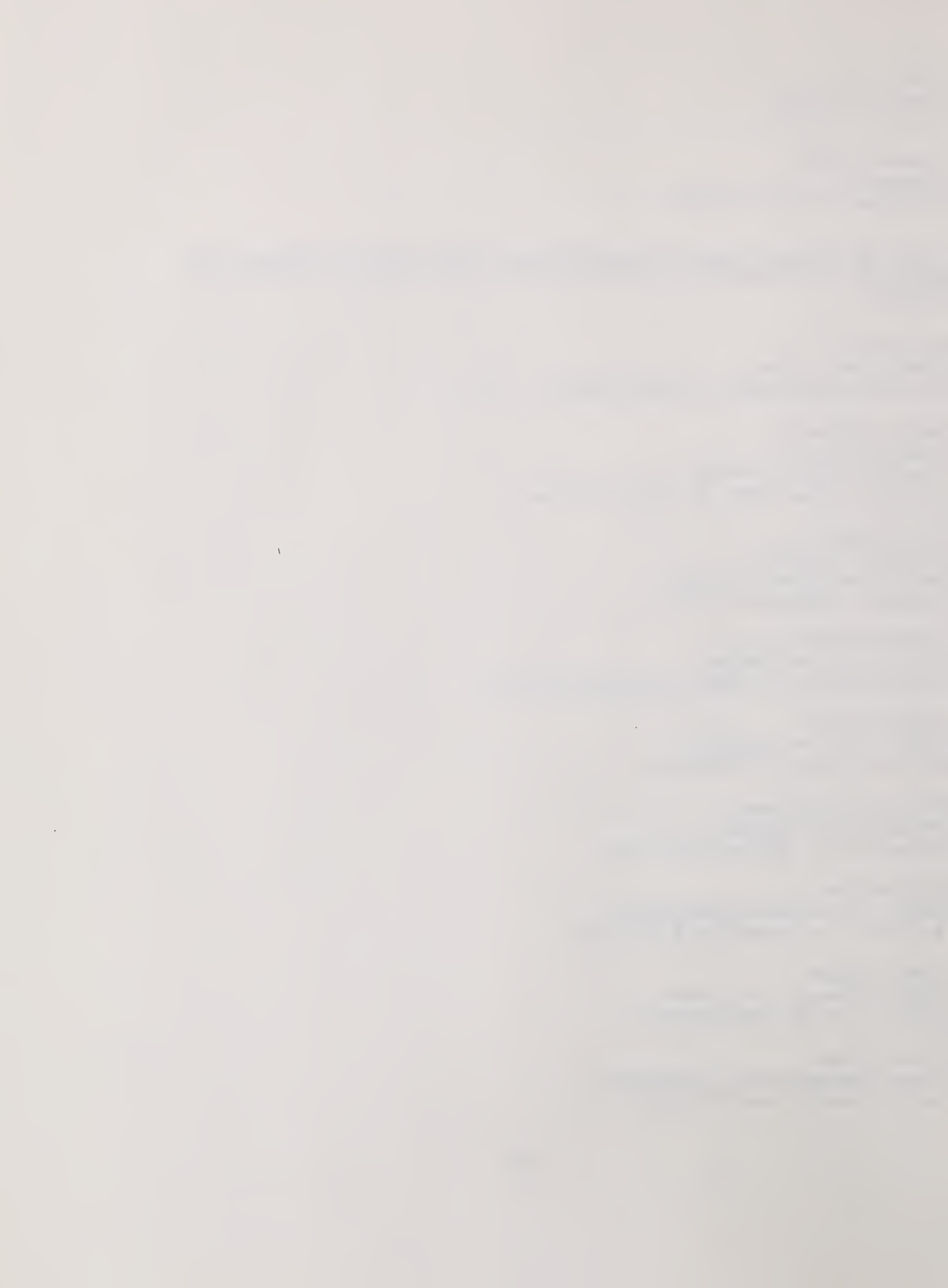
Harold Nelson
Center for Fire Research
National Bureau of Standards

Dr. H. Richard Lamb
Professor of Psychiatry
University of Southern California

Richard Best
Senior Fire Analysis Specialist
National Fire Protection Association

James McNamara
District Manager, Worcester
Social Security Administration

David Dunham
Claims Representative, Worcester
Social Security Administration



APPENDIX C

STATUTES AND REGULATIONS

1. 104 CMR 2.00, Department of Mental Health Facilities Regulations

2. 104 CMR 3.00, Department of Mental Health Regulations for Admissions to Facilities.

3. 104 CMR 15.00 - 18.00, Department of Mental Health Licensing Regulations.

4. 104 CMR 24.00, Department of Mental Health Regulations on Department Investigations.

5. 105 CMR 150.00, Department of Public Health Rules and Regulations for the Licensing of Long-Term Care Facilities.

6. 105 CMR 151.00, Department of Public Health Revisions to General Standards of Construction for Long-Term Care Facilities in Massachusetts.

7. M.G.L. c. 140, ss 22-32, regarding Licensing of Lodging/rooming houses.

8. M.G.L. c. 148, regarding Fire Prevention Requirements for Lodging/rooming houses.

9. 527 CMR, Article 24.00, regarding Fire Prevention Requirements for Lodging/rooming houses.

10. 780 CMR, Articles 2, 6, 9 and 12, provisions of the State Building Code regarding Lodging/Rooming/Boarding Houses and Group Homes.

DEPARTMENT OF MENTAL HEALTH RECORDS, STANDARDS, POLICIES, PROCEDURES, MEMORANDA, AND STUDIES

9. Worcester State Hospital records of all registered residents of Central Community Home on April 19, 1983.

10. Department of Mental Health Licensing Site Survey.

11. Department of Mental Health Quality Asssurance Review of Community Clinics in the Greater Worcester Area, March 19, 1979.

12. Greater Worcester Mental Health and Retardation Area Monitoring Report, Community Mental Health Center, April 6, 1983.

13. Worcester Mental Health and Mental Retardation Area Office Report to the Area Board, June 1983.

14. Natalie Ammarrell, "Study of the Future of Worcester State Hospital and of Public Mental Health Care in Central Massachusetts", Brandeis University report under contract with Department of Mental Health, May 1981.

15. Mary B. Tetro, "An Analysis and Management Evaluation of the Worcester Area Office of the Department of Mental Health's Community Clinics, Worcester Area Community Mental Health Center", March 1981.

16. Department of Mental Health Guide for Implementation of Regulations for Department Investigations, March 17, 1983.

DEPARTMENT OF MENTAL HEALTH RECORDS, STANDARDS, POLICIES, PROCEDURES, MEMORANDA, AND STUDIES (CONTINUED)

17. Department of Mental Health Residential Site Report, May 1983.

18. Policy and Procedures Manual, Social Service Department, Worcester State Hospital.

19. Policy and Procedures Manual for Patient Records, Worcester State Hospital, May 4, 1983.

20. Department of Mental Health Standard State Hospital Organization Workplan, October 12, 1982.

21. Department of Mental Health Policy Memo No. 83-9 on Health, Safety, and Welfare of Department Clients in Residential Settings, June 24, 1983.

22. Department of Mental Health Standard Facilities Operations Manual, Spring - Summer, 1983.

WORCESTER AREA COMMUNITY MENTAL HEALTH CENTER RECORDS, STANDARDS, POLICIES, PROCEDURES, MEMORANDA, AND STUDIES

23. Worcester Area Community Mental Health Center records of all registered residents of Central Community Home on April 19, 1983.

24. Orientation Manual, Worcester Area Community Mental Health Center.

25. Worcester Area Community Mental Health Center: Manual of Clinical Policies and Procedures, September, 1982.

26. Housing Policy, Community Mental Health Center.

27. Julie B. Tessler, "Housing the Mentally Ill: A Needs Assessment for Worcester Area Community Mental Health Center", August 5, 1983.

OTHER RECORDS, DOCUMENTS AND INVESTIGATIONS

28. Client Benefit Information for Central Community Home Residents.

29. Department of Public Health Division of Health Care Quality Deficiency Statement for Worcester Area Community Mental Health Center, August 30, 1983.

30. Massachusetts State Police Report of the fire at 809 Main Street on April 19, 1983.

31. All Building Code Inspection records for Central Community Home, 809 Main Street, Worcester Division of Building Inspection, Department of Code Inspection.

32. Worcester Fire Department, Fire Incident Report, 809 Main St., April 19, 1983.

OTHER RECORDS, DOCUMENTS, AND INVESTIGATIONS (CONTINUED)

33. Worcester Fire Department, Fire Incident Report, 809 Main Street, March 19, 1983.

34. Worcester Fire Department Records of Inspections at 809 Main Street.

35. Summary Investigation Report, Central Community Home Fire, National Fire Protection Association, September 1983.

36. Newspaper reports from the Worcester Telegram, Worcester Gazette, and Worcester Magazine, 1980-1983.

37. U.S. Census and Economic Condition Information for Worcester, Worcester Area Chamber of Commerce, 1981.

38. Written complaints about Central Community Home received by Department of Mental Health and Massachusetts Senate.

39. Two claims presented under M.G.L. c. 258, Tort Claims Act, by attorneys representing families of two of the deceased residents of Central Community Home.

LOCAL, STATE, AND NATIONAL STUDIES AND REPORTS ON MENTAL HEALTH, HOMELESSNESS, AND FIRE SAFETY

40. "Profile of the Homeless in Massachusetts", Governor's Office of Human Resources, April 28, 1983.

41. "Everybody has the Right to a Decent Home", Worcester Committee on Homelessness, April 27, 1983.

42. Elizabeth Testa, "What To Do," unpublished paper, Holy Cross College, May, 1983.

43. "A Study of Federal and State Actions To Safeguard The Health and Safety of Board and Care Home Residents", Office of the Inspector General, U.S. Department of Health and Human Services, April, 1982.

44. "A Review of Rest and Boarding Home Licensing Under Section 1616 (e) of the Social Security Act, Commonwealth of Massachusetts," Office of Inspector General, U.S. Department of Health and Human Services, Office of Audit -- Region I, May 1982.

45. H. Richard Lamb, "Maximizing the Potential of Board and Care Homes," in R. Budson (Ed.) Issues in Community Residential Care, San Francisco: Jossey Bass, September 1981.

46. Fire Safety in Boarding Homes, National Fire Protection Association, Quincy, Mass.

47. "Promising Improvement in Health Care Fire Safety," in Fire Journal, Quincy, Mass., July 1983.

48. Health Care Safety, Reports and Articles, National Fire Protection Agency, Quincy, Mass.

49. "A Fire Safety Evaluation System for Board and Care Homes," Department of Health and Human Services, Washington, D.C. March 1983.

50. "Recommendation For Improving Fire Safety in Lodging Houses", Worcester Department of Code Inspection, April 25, 1983.

51. Carmen D. Solomon, Analyst in Social Legislation, "Board and Care Homes and the Keys Amendment", Education and Public Welfare Division, Congressional Research Service, The Library of Congress, June, 1982.

52. "Assuring Quality of and Access to Health Care: An Issue Paper," Massachusetts Department of Public Health, September 1983.

53. Statistical and Policy Information on Rest Homes, Department of Public Health.

The Commonwealth of Massachusetts
Executive Office of Human Services
Department of Mental Health
160 North Washington Street
Boston, Massachusetts 02114

Callahan, Jr., Ph. D.
Commissioner

AREA CODE (617)
727-5600

M E M O R A N D U M

TO : John Mudd
Acting Secretary of Human Services

FROM: James J. Callahan
Commissioner

DATE: 6 March, 1984

RE : DMH Response to EOHS Worcester Fire Report

While reviewing the EOHS Worcester Fire Report, it was brought to my attention that the National Fire Protection Association (NFPA) has issued its own investigative report on the fire at Central Community Home. It is important to note the differences between the two reports. The NFPA report documents the inadequacy of existing fire and building code requirements that relate to the use of the building at 809 Main Street as a lodging home. NFPA found that the persons living in the home faced an unnecessary risk because of these deficiencies - a risk which was independent of the fact that they had been or were clients of the Department of Mental Health. It is obvious that the NFPA findings must be addressed by those agencies responsible for the development and enforcement of fire and building codes. The EOHS report focuses primarily on the occupants of the Home and on their relationship to the Worcester Area mental health service system. While the balance of this memorandum will address the EOHS findings concerning the provision of mental health services, the issues raised by the National Fire Protection Association are also of immediate concern to the Department. It is my expectation that EOHS will pursue an appropriate resolution of these fire safety code issues as part of the Keys Amendment review process referenced at the end of the EOHS report.

The EOHS investigation team has made detailed findings concerning community and inpatient mental health issues in the Worcester Area. These findings and the related background discussion included in the Report represent an impressive and ambitious effort by the investigators to identify strengths and weaknesses in the Commonwealth's mental health service and regulatory system in relationship to the circumstances of the

mentally disabled individuals who were at Central Community Home on April 19, 1983. The Report has implications for statewide management and policy development as well as findings and suggestions that are specific to the Worcester Area.

I will address the statewide implications of the Report in the balance of this memorandum. To ensure the accuracy of the findings and suggestions that are specific to the Worcester Area and to form a sound basis for a complete Department of Mental Health response and action plan, I have asked the Worcester Area Director to provide me with his response and action plan relative to each of the findings that is not otherwise addressed through the statewide initiatives set forth in this memorandum. The Area Director's response is due at this office on March 19, 1984.

From a statewide perspective, four major areas of concern are contained in the Report: (1) inadequacies in state hospital admission, discharge and treatment decisions; (2) inadequacies in the supply and the regulation of housing made available in the private housing market for indigent mentally disabled individuals; (3) a need for more case management and other community support services for indigent mentally disabled individuals; (4) a need for fire safety training programs. I will address each of these areas of concern below:

(1) <u>State Hospital Admission, Treatment and Discharge Decisions</u>

On January 18, 1984, the Department of Mental Health issued a new and comprehensive Mental Health Inpatient Facility Operations Manual. The issuance of the Manual culminated one and one-half years of intensive work by Department staff to develop a statewide standard for the management, organization, treatment services and physical plan of the public mental health hospitals. An audit of existing policies at mental health facilities conducted by the Department in August of 1982 documented the lack of consistency among the inpatient facilities.

The Manual has four substantive sections: Program Management; Client Management; Client Services; and Physical Plant Management. In its entirety, the Manual is applicable to the seven state hospitals. In addition, the Client Management section is applicable to the ten inpatient units managed by the state-operated community mental health centers. This section delineates Department policy relative to admission, commitments, treatment, aftercare planning, special treatment and emergency proceudres, discharges, transfers and absences.

Program Management defines the overall organizational structure and administrative operations for each facility. This section details policies such as staffing, client records, client rights and staff development. In addition, the roles and responsibilities of key personnel are delineated. A Facility Director is responsible for administrative functions and Area Directors are responsible for clinical units. An Executive Committee oversees the overall operations of the hospital.

Client Services and Physical Plant sections detail policy relative to client support services such as pharmacy, laboratory and emergency medical and physical plant issues such as housekeeping and dietary.

The issuance of the Manual addresses the findings of the Worcester Fire Report that relate to Worcester State Hospital. The Manual contains clear policy statements and standards regarding the areas found to be deficient in the Report. Specifically, the Manual includes sections on discharge, treatment, aftercare, and recordkeeping. These sections include policy and delineate the parties responsible for implementation and compliance.

(2) <u>Housing-Inadequate Supply and Need for Regulation</u>

A large number of discharged mental patients are poor. Many of them are not able to obtain full-time jobs and have to subsist on general relief, SSI, SSDI, or some other income assistance program. The amount of money available to them for their ordinary needs of daily living is not great and, hence, they must purchase from the low income market. The low income housing market is characterized by substandard housing units, extreme scarcity and very high occupancy rates. It will probably become even more difficult to find adequate low income housing in the coming years. The patients served by the Department then are faced with finding appropriate housing within that limited market. The findings of the Worcester Fire Report document the scarcity of housing as well as the fact that a number of mentally ill patients are living together in various types of housing units because it is economically efficient.

It is the position of the Department of Mental Health that the on-going mental health needs of discharged mental patients must be met by the Department. It is the Department's position also, however, that most mental patients will need to depend upon the local housing supply and that specialized housing developed by the Department of Mental Health will only meet a part of the need. Therefore, it is imperative that the Department do what it can to insure that the local stock of housing is appropriate for discharged patients.

The Department, therefore, will be instructing each of the Area Directors to undertake the following.

1. To identify in the community each housing unit where there is a large block of mental patients. As a guideline, any apartment or housing unit or building serving 8 or more unrelated individuals that may have over thirty-three percent discharged mental patients should be included on a current inventory list held by the Area office.

2. The Area Director should meet with the local fire department to insure that those housing units meet all applicable housing and building codes. In addition, the Area Director should attempt to get the local fire chief to conduct routine inspections of those facilities and to run fire drills to insure that occupants are able to navigate their way out of the house.

3. The Area Director should develop a program of regular clinical visitation to those housing units to monitor the status of discharged clients. This could be done on an every four month basis and would be in addition to any visits to particular clients.

4. Area Directors should identify the landlords and/or building managers and make arrangements with them to contact the appropriate mental health resource if problems are developing with particular discharged clients.

(3) Need for Case Management and Community Support Services

The Department of Mental Health is currently implementing new and strengthened community based services designed to improve aftercare and support for clinically mentally ill persons who occasionally utilize state mental hospitals for inpatient services. In addition, DMH has requested substantial new funding to continue the development of such services in FY'85.

The types of services being developed include expanded residential programs intended to provide appropriate supportive living environments for recently discharged individuals; structured day programming designed to facilitate transition from the hospital to more independent community settings; emergency shelters for persons needing short-term residential placements; social clubs providing ongoing socialization and mutual support

for clinically mentally ill persons; crisis intervention services aimed at preventing unnecessary institutionalization; and crisis beds, apartment programs, and specialized case management for mentally ill homeless individuals.

The following is a summary of initiatives begun in FY'84 and additional programs contained in the Governor's FY'85 budget.

FY'84

1)	Crisis intervention, emergency shelter, and court clinic services in District I (Western Mass.)	$ 739,000
2)	34 new residential slots and 6 new day program slots in District I	$1,600,000
3)	Eleven new social clubs	$ 250,000
4)	Homeless Case Management project in Boston (currently funded by federal funds)	

FY'85

1)	New consent decree services in District I including 99 residential and day program slots, community support services and case management for 100 new clients (a pilot project to be undertaken in two Areas), and housing assistance for 150 clients	$2,103,940
2)	Expanded services for homeless mentally ill persons, including crisis beds, apartment programs, and case management	$ 850,000

(4) Fire Safety Training of Community Program Staff

In September, 1983, the Department of Mental Health completed an analysis of the need for fire safety training of community vendor staff serving people who are mentally retarded, mentally ill, and emotionally disturbed adolescents. The analysis included information on the number and type of community programs; numbers of staff to be trained; and cited the fiscal and human resources necessary to accomplish the training task. Following this analysis, two potential training vendors were identified, the Massachusetts Firefighting Academy and the Civil Defense Agency Training Academy.

Both vendors submitted curriculum outlines, instructor credentials and costs in December, 1983. Following a review by Commissioner Callahan, it was agreed that the Department will offer the Massachusetts Firefighting Academy a $10,000 contract to provide training for approximately 500 mental retardation community staff, and to require mental health and child adolescent community programs to sponsor at least one staff per program at fire safety training provided by the Massachusetts Firefighting Academy. Additionally, it was decided that the Department would contract with the Civil Defense Agency to conduct two pilot training programs for vendor staff and Department personnel. An evaluation process is being designed to ascertain the efficacy of the training provided by both vendors. FY'85 Firesafety training will be contracted based on the evaluation outcome.

James J. Callahan, Jr., Ph.D.
Commissioner

The Commonwealth of Massachusetts
Executive Office of Human Services
Department of Mental Health
160 North Washington Street
Boston, Massachusetts 02114

AREA CODE (617)
727-0470

MEMORANDUM

TO: James J. Callahan, Jr., Ph.D.
Commissioner

FROM: John R. Ford
Worcester Area Director

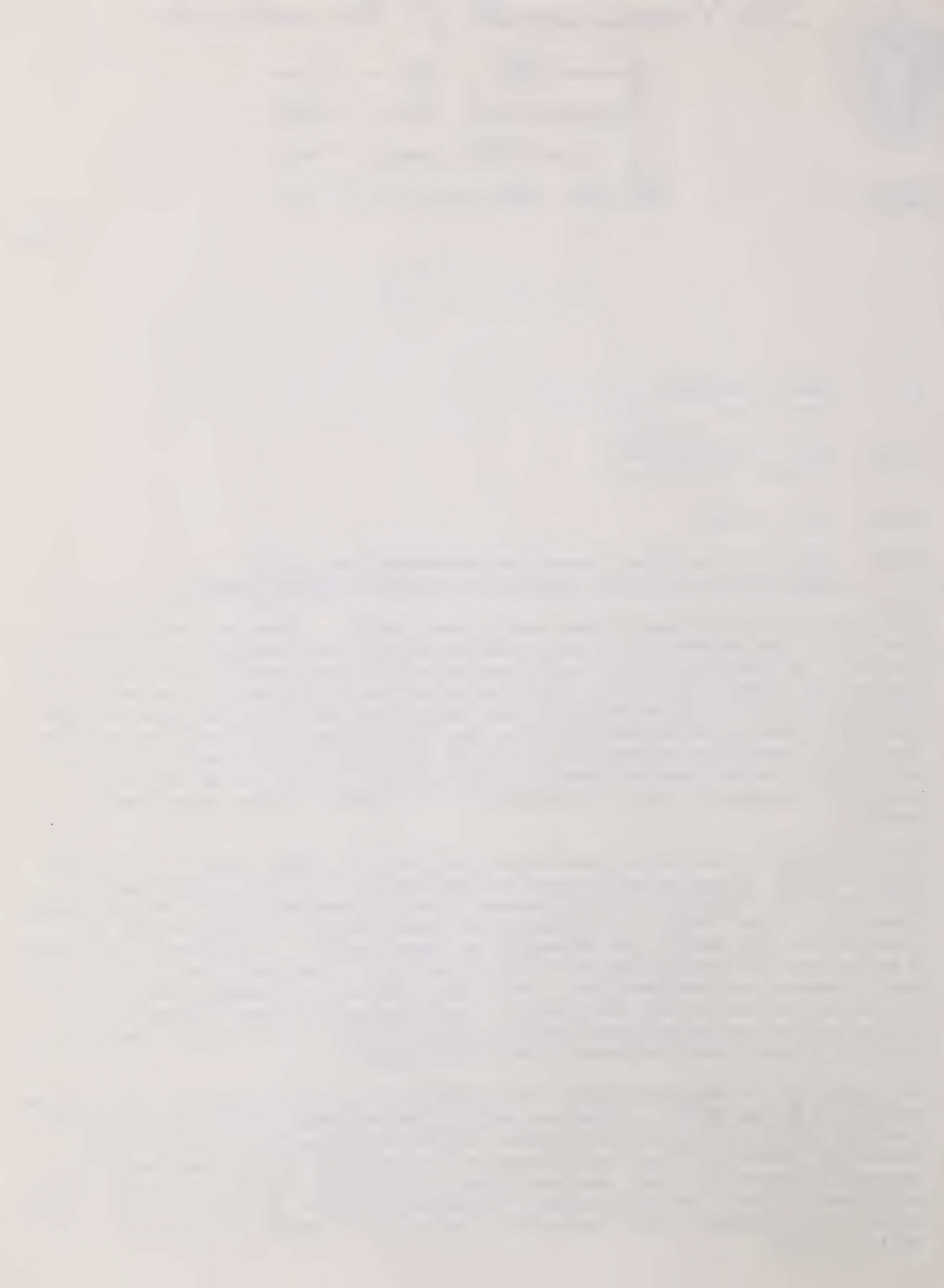
DATE: March 16, 1984

SUBJ: Worcester Area Office Comment on Recommendations in the EOHS Report on the April 1983 Fire at Central Community Home

The fire at Central Community Home was a great tragedy. Subsequent reporting in the local press underscored the fact that people who died there were not alone and isolated, but rather part of a caring community of fellow residents, local business owners, and clients and staff of the Area mental health system. The report done by the Executive Office of Human Services raises a number of issues, some of which the Area Office is in agreement; others upon which we have a different perspective. While it is important to keep the gravity of the tragedy in mind and to accept responsibility to act where we have the authority and resources to do so, it is important to note the stage of development of the Worcester Area mental health system.

While the bulk of deinstitutionalization from Worcester State Hospital took place prior to 1975, it was not until that year that the first eight-client community residence was established in this community. At the present time, there are approximately 82 client "beds" in the Greater Worcester mental health system that are financed and regulated by the Department of Mental Health. An additional 54 beds in a well-controlled environment (West Side House) were in use until the spring of 1982 when a federal decision resulted in the elimination of reimbursement for a portion of the cost of care at West Side House. The 54 patients at West Side were then placed wherever placements were available in the community and, in the ensuing year, several of these people returned to the state hospital.

Worcester did not begin the formal development of its community mental health system until late in the 1970's. It was not until 1979-1980 that the variety of residential day activity, vocational, outreach, and outpatient services that now exist within the Community Mental Health Center, the Jewish Home for the Aged, and other agencies emerged. No sooner was the system in place than federal cut-backs resulted in a loss of a half a million dollars of program financing in 1981 and 1982. In spite of this, the system has made impressive gains both in community programs and in the state hospital.



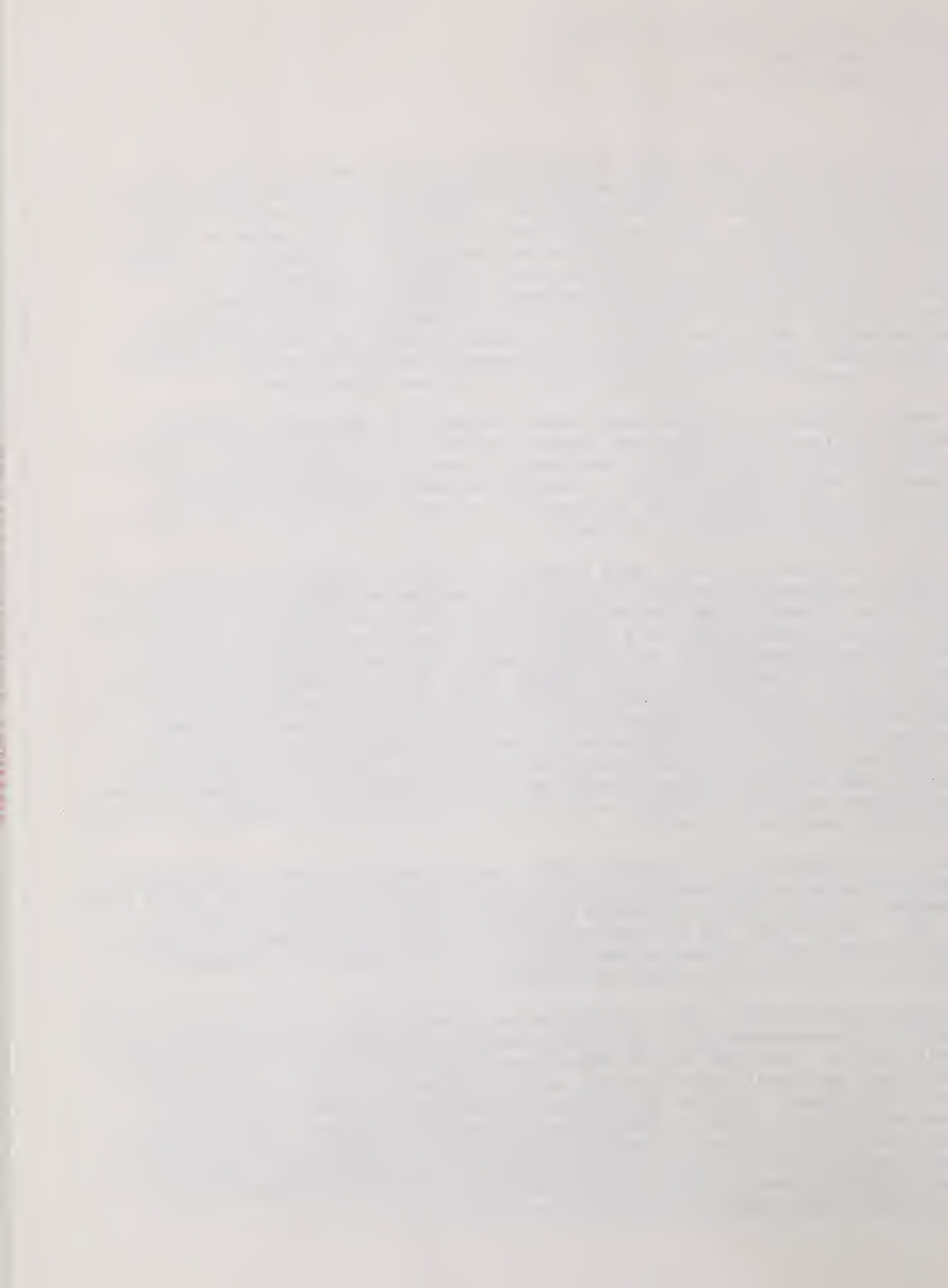
The EOHS report sites inadequacies in the records of the Greater Worcester Unit at Worcester State Hospital. This has been a perennial problem and a major concern in seeking JCAH and Title XIX recertification. Beginning several months before the 809 Main Street fire, and while the Worcester Area Director also served as Acting Hospital Administrator, a concerted effort was developed to reorganize the hospital and to begin to improve many of its practices including record keeping. At this juncture, there has been substantial documented progress in improving record keeping practices in all of the units at the state hospital. Psycho-social histories and social work notes in the Greater Worcester Unit are now at a 97 percent completion rate, while Title XIX required treatment planning and record documentation in all phases is at a 60 percent rate and continually improving.

In a number of places, the EOHS report notes the need for additional residential programs. The report also notes the attempts on the part of Worcester to re-program funds from lower priority areas to meet housing needs (the housing support team at the Community Mental Health Center). Recently, we have initiated cooperative efforts with the appropriate City agencies that we hope will lead to improvement in housing conditions for mentally ill people.

In the past two years, we have done a number of things to improve the links between the Greater Worcester Unit at the state hospital and the community mental health center system. These include the assignment, well before the fire, of a former state hospital social worker to act as a liaison between the Community Mental Health Center's various divisions and the inpatient unit. This social worker "trouble-shoots" referrals. Additionally, the clinical staff of the inpatient unit and the clinical staff at the Community Mental Health Center meet together over specific client treatment plans on a regular basis. The Director of the Emergency Mental Health Service and the Clinical Director of the CMHC regularly participate in a weekly admissions review meeting in the state hospital. Lastly, the Medical Director at the CMHC and the Clinical Director in the inpatient unit are one and the same person, thereby promoting the opportunity for integrated clinical management of these two separately administered units.

We note the finding that the Emergency Mental Health Service is now less accessible than when operated at City Hospital. We agree that this is the case. We expect that the emergency service will be relocated to another site on or around the first of July, 1984. Neither DMH nor the CMHC wished to see this service leave City Hospital. We still consider that the most appropriate site but the return of the emergency service to that site is well beyond our control.

In the EOHS report finding (#E4), it references extended visit. We believe that this finding is a misunderstanding of the relationship of the hospital to the rest of the community system. The Department of Mental Health operates Worcester State Hospital. The Department of Mental Health operates and/or finances the bulk of the community mental health system. They are not separate and distinct in their sponsorship. The Area Office is the point of integration of these two systems. In our opinion, the following of patients by the community system under contract to the Department of Mental Health meets the spirit of the extended visit requirement. Prior to the fire at 809 Main Street, we began discontinuation of the use of extended visit as an unnecessary legal technicality in this day and age.



Finally, and again it is important to put this accident in an historic perspective, massive deinstitutionalization occurred before readiness for it. Worcester, since the late 1970's and early 1980's, has been improving on volume and scope its community mental health system for service to severely disabled persons. This improvement can continue with proper support from the Legislature, the Governor, the Executive Office of Human Services, and from within DMH itself. One of the major problems that we face is the loss of quality residential alternatives to the state hospital, such as the former West Side House. This innovation in mental health services was both effective and economical. It was a severe set-back to this local system to lose 54 quality client placements.

It is the Area Office's strong recommendation that the West Side prototype be revived and replicated. Further, in view of the substantial loss of lower income housing in Worcester (over 500 single-room occupancies lost in the last few years), we recommend that EOHS take positive action to bring together the Executive Office of Communities and Development, the Department of Mental Health, both centrally and in Worcester, and appropriate City agencies and authorities to bring about a significant and substantial improvement in housing for the mentally handicapped. The substantial infusion of funds into the Executive Office of Communities and Development budget in this legislative session provides the opportunity to assist Worcester. The local municipal agencies, the DMH Area Office, and the Community Mental Health Center stand ready to act.

Recently, the Worcester Area Office and the Area Mental Health and Mental Retardation Board agreed to make substantial changes in the use of its children's mental health services fund so that a larger proportion of those funds will be utilized for serving more severely disabled young people. In this and other changes in the service delivery system, we have shown both the willingness and capacity to make difficult changes locally, but our resources are limited and eventually the state will have to determine whether or not it wishes to expend the funds necessary to complete the job of communitizing mental health services.

JRF:kfb

The Commonwealth of Massachusetts
Executive Office of Human Services
One Ashburton Place, Room 1109
Boston, Massachusetts 02108

Secretary

MEMORANDUM

TO: John Mudd, Acting Secretary

FROM: Mark Coven, Assistant Secretary

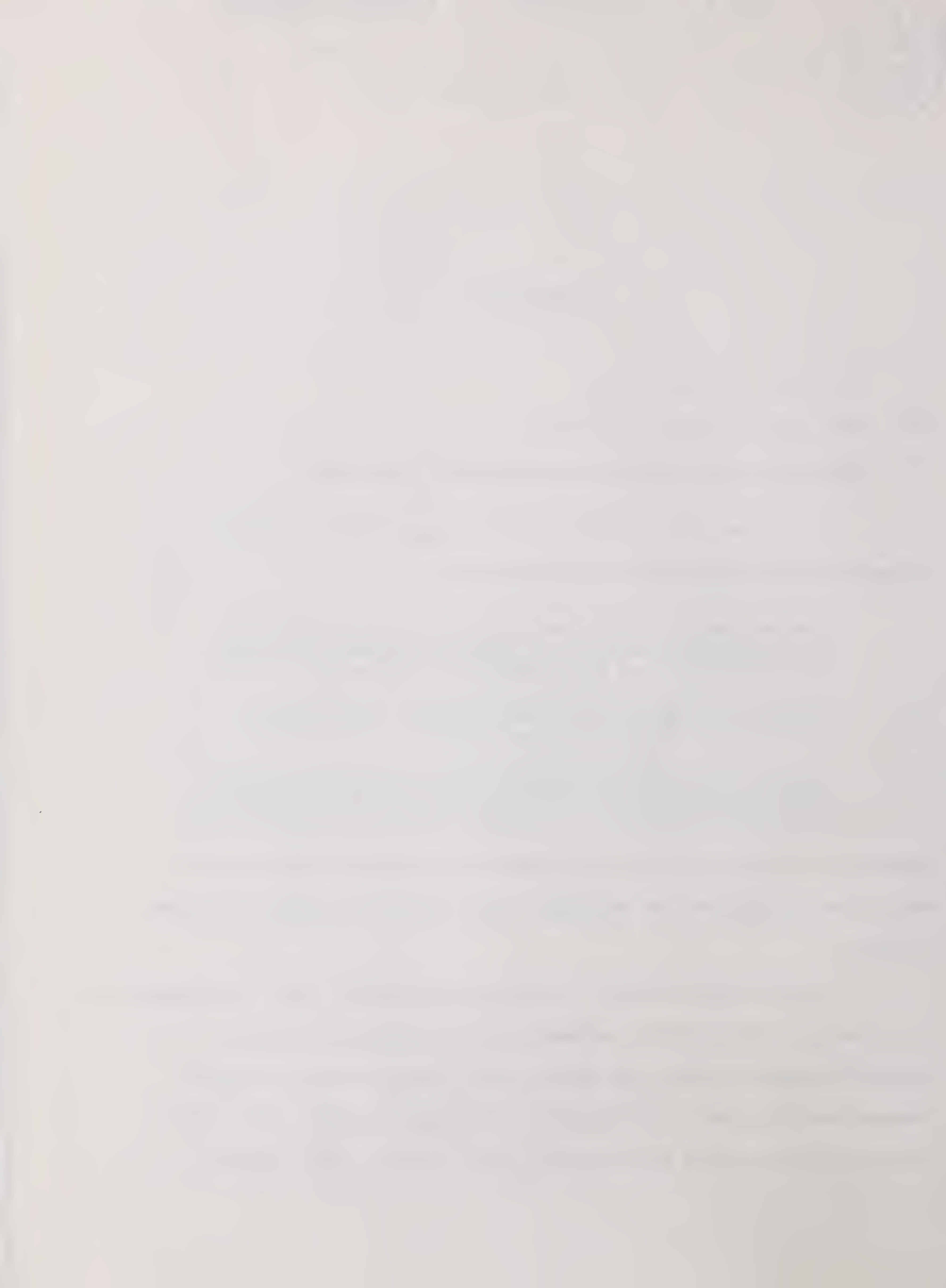
RE: EOHS Action Plan in Response to Worcester Fire Report

As you know, Section 1616(e) of the Social Security Act was revised in 1976 by the so-called Keys Amendment to:

- o assure that the states had standards governing the safety and appropriate operation of certain residential settings serving elderly and handicapped SSI recipients;
- o prohibit the use of SSI funds to support sub-standard facilities serving such persons; and,
- o require the states to publicize the availability of state/local standards and enforcement procedures, as a means of involving the public in monitoring compliance with standards.

Amendments to Section 1616(e) were approved by Congress in 1981 and, as a result, new regulations were developed. The rules were issued on November 30, 1983.

The Department of Social Services, and then EOHS once it was designated as the agency responsible for implementation of the Keys Amendment, originally determined that only certain state funded or state licensed programs were required to be regulated by the Keys Amendment. When this determination was called into question by the federal audit referred to



in the Worcester Fire Report and the Report's own findings, EOHS convened an interagency work group to determine whether other residential settings, such as Central Community Home, fall within the definitions in the Keys Amendment. The agencies that participate on the work group are those that have statutory authority to either license or regulate residential settings likely to serve elderly or handicapped persons receiving SSI benefits. The Department of Mental Health is a participant, along with the Departments of Public Health and Public Welfare, the Office for Children and the Executive Office of Elder Affairs. The Executive Office of Public Safety may be asked to participate, depending upon whether building code compliance issues are raised by the group.

Once there is agreement on the residential facilities which are covered by the Keys Amendment, the Executive Office of Human Services will work with these agencies to implement this Amendment and subsequent reporting to the federal government. In some instances, implementation will be a continuation of current licensing activities and in some instances implementation may require the promulgation of new regulations.

Another task of this work group will be to explore inclusion of certain residential settings, where SSI recipients reside, for payment of higher Supplemental Social Security benefits than now authorized. Such a financial incentive could encourage landlords to comply with needed standards and thus ensure better quality services for SSI recipients. Because it is a totally state-funded supplement, however, the question of which types of residential facilities qualify will be carefully considered,

and will be balanced against other possible approaches, such as increasing funding to agencies such as DMH for state-run or state-contracted housing, or targeting already appropriated housing money to clients of human services agencies who are now unable to find suitable housing.

We expect to complete the above tasks by December 31, 1984.

MC:mdm

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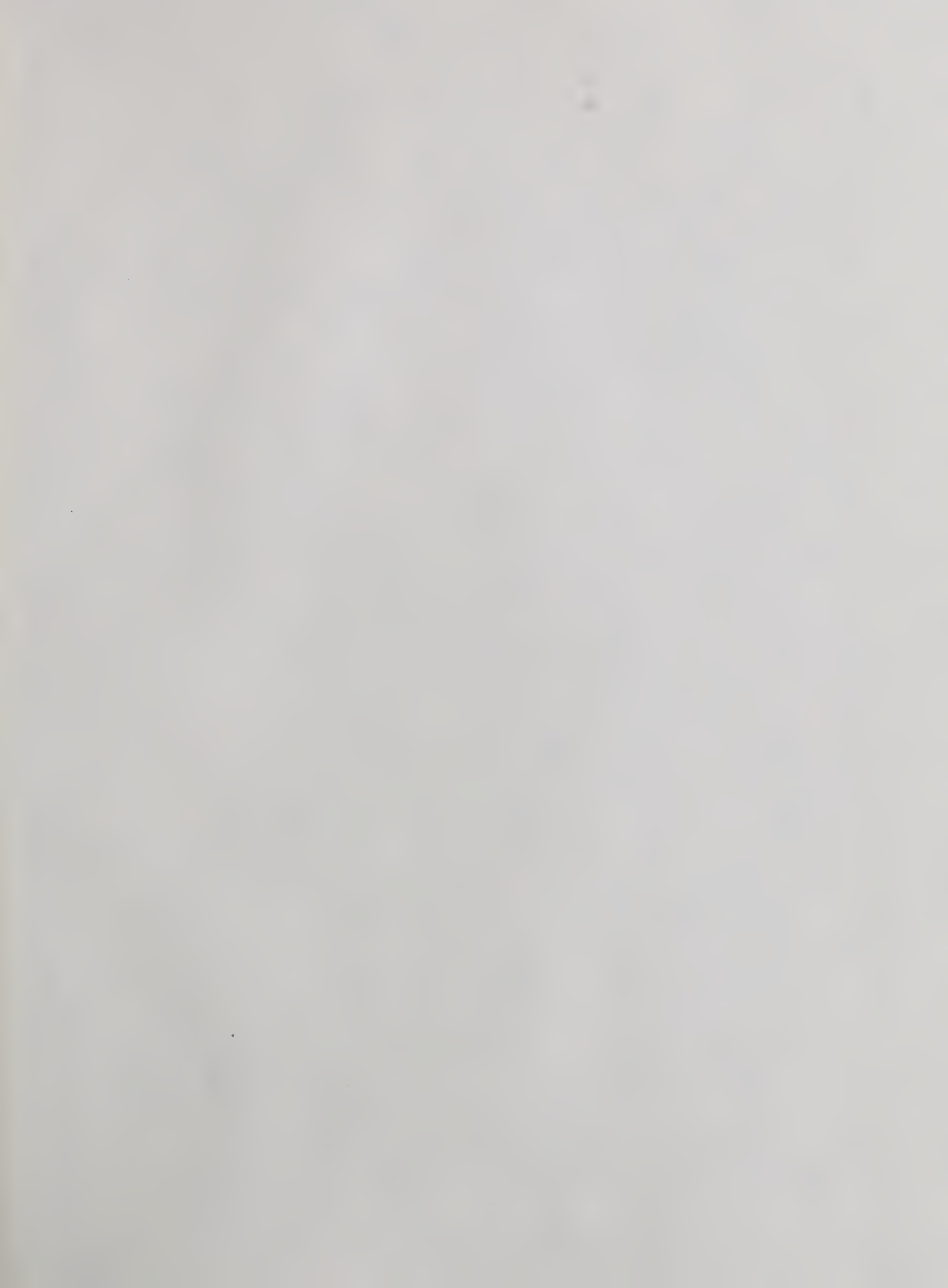

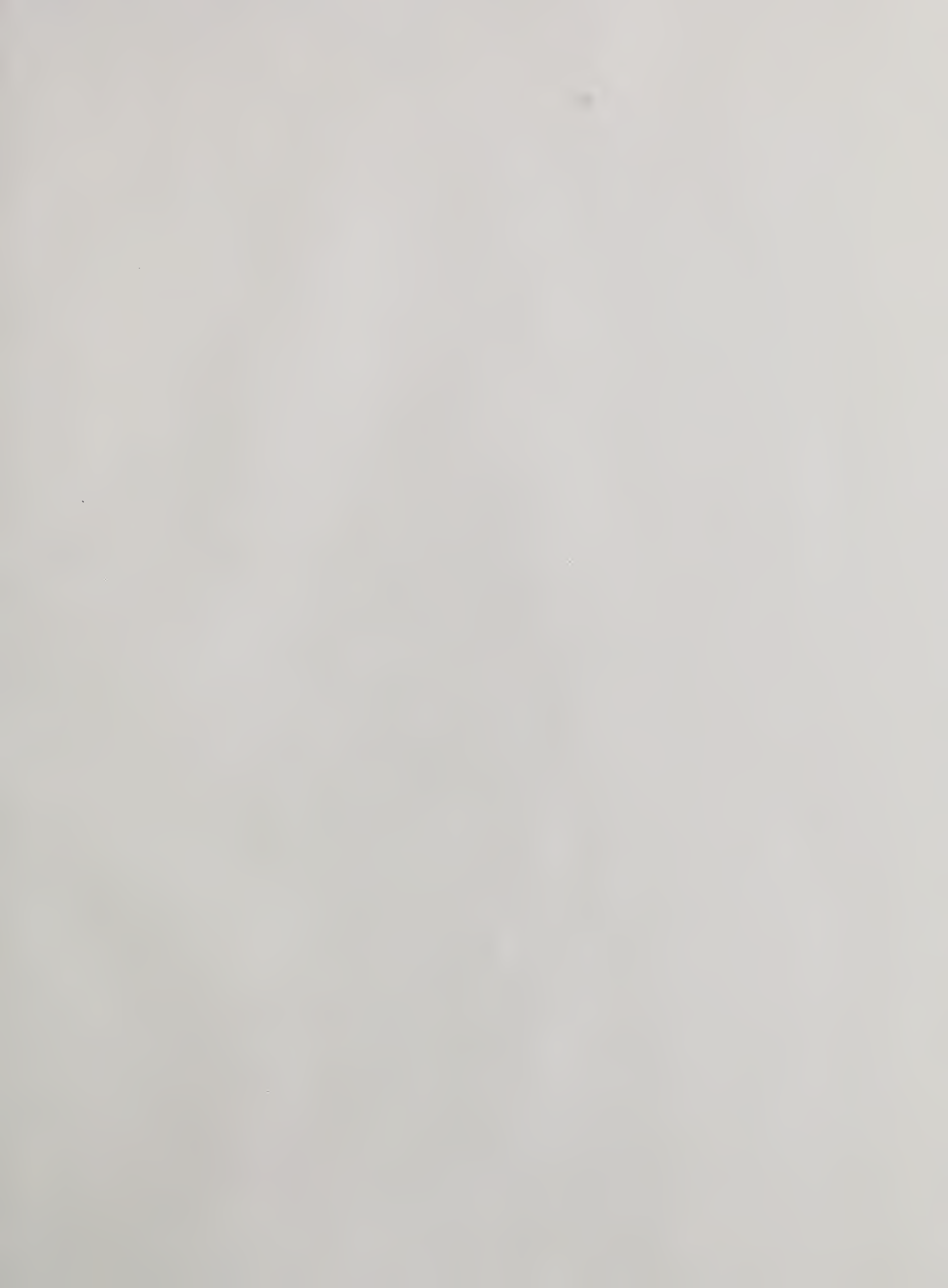

ACME
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CHARLESTOWN, MASS.